**NEW PATIENT QUESTIONNAIRE**

**Please nominate a local Pharmacy that you would like your prescriptions to go to**

Asda  Boots High Street  Boots St Peters Hill  Superdrug  Lloyds High street  Lloyds Alma Park

Co-op Winchester Rd  Co-op Hornsby Rd  St Peter’s Hill  None

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to SMS Yes  No

Country of Origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **1st Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ English Speaker \_\_\_\_\_\_**

Ethnicity:

White British  British or Mixed British  Irish

Other White  White & Black Caribbean  White & Black African

White & Asian  Other mixed background  Indian & British Indian

Other Asian background  Pakistani or British Pakistani  Caribbean

Other Black background  Bangladeshi or British Bangladeshi  African

Other Ethnic Category  Ethnic Category not stated  Chinese

Next of Kin (Name, Telephone No and relationship) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_FOR CHILDREN ONLY**

Please give details of those who have parental responsibility for this child :

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Should you wish to authorise any person other than those who have parental responsibility to bring the child to appointments/ speak to a GP on your behalf please give their details below:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARERS**

Do you need / have anyone who looks after you or your daily needs as a Carer? Yes  No

If “Yes”, would you like them to deal with your health affairs here? Yes  No

(T**he receptionist can help with these arrangements**)

Do you care for anyone else? Yes  No

If “Yes” please print patients name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION**

Should you have any specific communication needs ie large print, interpreter, please specify here :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH**

Smoker: Yes  No  No/day \_\_\_\_\_\_\_ Smoking Advice: Yes/No

Past Smoker: Yes  No  No/day \_\_\_\_\_\_\_ Quit (year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked Yes  No

Alcohol per week Pints of Beer \_\_\_\_\_\_\_\_\_ Glasses of Wine \_\_\_\_\_\_\_\_\_ Spirits \_\_\_\_\_\_\_\_\_\_\_

1) How often do you have a drink that contains alcohol?

Never  Monthly or Less  2-4 times per month  2 – 3 times per week  4+ times per week

2) How many standard alcoholic drinks do you have on a typical day when you are drinking?

1 – 2  3 – 4  5 – 6  7 -8  10+

3) How often do you have 6 or more standard drinks on one occasion?

Never  Less than monthly  Monthly  weekly  daily or almost daily

Exercise: Do you enjoy or Avoid \_\_\_\_\_\_\_\_ If so Light/Moderate/Heavy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet: Normal  Vegetarian  Vegan

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Allergies: (to medicine, animals etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Members History (Mother, Grandfather etc)**

Angina \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Other Heart Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_**

Please give details of any past serious illnesses/fractures/operations/births etc. on the back page





**Record sharing**

Do you consent to the sharing of data recorded here at St Peter’s Hill Surgery with any other organisations that may care for you?

**Sharing Out**

Yes – share data with other organisations

No – Do not share any data recorded here

**Sharing In**

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make the data shareable?

Consent given

Consent refused

Name ………………………………………. Date of Birth …………………..

Signed ………………………………………. Date……………………………..

**PLEASE tick both sections**

**Record sharing**

Do you consent to the sharing of data recorded here at St Peter’s Hill Surgery with any other organisations that may care for you?

**Sharing Out**