New Patient Questionnaire

Patient Details					
Full name					
Date of birth					
Address					
Tel No.					
Ethnic Origin *Please circle*	British Indian Other:	Irish Pakistani	Scottish Bangladeshi	Welsh African	Polish Chinese
First language		Interpreter required?		Yes	No

Health Information			
Height		Weight	
Smoking status	Smoker ☐ Ex-smoker ☐ Never Smoked ☐ If you have indicated you are a smoker would you like smoking cessation support? Yes ☐ No ☐		
Medical conditions			
Repeat medication *(please supply copy repeat slip)*			
Pharmacy Nomination		Keep here	Yes
Allergies *(please specify)*			
Please circle below:			
Are you a carer		Yes	No
Do you have a carer		Yes	No
Are you a HM forces veteran?		Yes	No
Do you have or have you ever had, any social worker involvement in the family		Yes	No
If you are aged over 16 years old you will automatically be registered for online services enabling you to make appointments and request medication. If you wish to opt out please circle opt out in the box to the right.		OPT OUT	
Are you a new patient from abroad? *If yes, please provide your vaccination status with this registration. If you are unable to supply this, please make an appointment with the practice nurse.*		Yes	No

Family History			
Asthma	Yes	No	Family member:
CVA/Stroke	Yes	No	Family member:
Diabetes	Yes	No	Family member:
Heart Disease	Yes	No	Family member:

Consent		
Do you consent for someone else to have access to your medical record? *If you consent for someone else to have access to your medical record then please complete a 'Patient Consent Form for another person to access their medical record'.*	Yes	No

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Communication						
Do you have a communication need? please circle	Wheelchair	Deaf	Blind	Learning Disability	Guide dog	Interpreter

Alcohol						
	0	**1**	**2**	**3**	**4**	**Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ a week	
How many units of alcohol do you drink on a typical day when you do drink?	0-2	3-4	5-6	7-8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in last year		Yes, during last year	
					Total Score	

Next of kin Details	
Name	
Address *(if not the same as patient)*	
Relationship	
Telephone Number	

Summary Care record
An NHS Summary Care Record is automatically created for you when you register. If you wish to opt out of this then please ask reception for the relevant form.

Patient Signature			
Signature		Date	

PRACTICE USE ONLY		
Vaccination Status Required?	Yes	No
If yes, has evidence of Vaccination Status Provided?	Yes	No
If evidence not provided, please make appointment with Practice Nurse		
Proof of address seen	Yes	No
Staff Initials:		
Date:		