ALCHESTER MEDICAL GROUP

CONFIDENTIAL

New Patient Questionnaire

Welcome to Alchester Medical Group. Please help us by filling in this questionnaire as accurately as possible as it may take some time for your previous medical records to reach us. We use a text message service for appointment reminders and campaigns – if you do not wish to be included in these then please inform a receptionist.

Personal Details

Title (Dr/Mr/Mrs/Miss/Other) ……Date of Birth ……..….

Surname …… …Forenames…….……

Address …….

Post Code …….. Tel No. Home ……Work…….....

Email ……. …….. Mobile Number……

Marital Status ……Previous/ Maiden Name …….....

Occupation ……

Name and Address of your previous doctor ……

Have you ever served in the Armed Forces? **Yes / No** If YES, please give dates ……..

Do you have a carer? **Yes / No**

Do you care for a chronically sick or disabled friend or relative? **Yes / No**

Past Health

Please give details of any significant illnesses, operations, accidents or other hospital contacts:

1. …… Date ……
2. …… Date ……
3. …… Date …….....
4. …… Date ……
5. …… Date…….
6. …… Date ……
7. …… Date…….

If you have any of the conditions listed below please make an appointment with the practice nurses for a NEW PATIENT Health Check.

Asthma	Yes / No	Stroke	Yes / No
Cancer	Yes / No	Diabetes	Yes / No
Epilepsy	Yes / No	High Blood Pressure	Yes / No
COPD	Yes / No	Heart attack/Angina	Yes / No

Lifestyle

Do you have any medication allergies **Yes** ☐ Details …… **No** ☐

Any other allergies or intolerances eg food, hay fever **Yes** ☐ Details …… **No** ☐

What is your height? …… What is your weight? ……..

Do your exercise: **Yes** ☐ How often per week …… **No** ☐

DO YOU SMOKE? Yes ☐ How many **per day**? Cigarettes ……. Cigars ……. Tobacco grams ……

Ex Smoker ☐ Year Stopped …… **Never Smoked** ☐

If you would like smoking cessation advice please make an appointment with a Practice Nurse

Have you had your blood pressure measured in the last 2 years? **Yes** ☐ **No** ☐
You are able to check your own weight and blood pressure using the machines in the waiting room at Langford Medical Practice and Victoria House Surgery

Family: Have any of your family (father/mother/sisters/brothers) suffered from:

ASTHMA …… …HIGH CHOLESTEROL ……..

DIABETES …… CANCER ……..

HIGH BLOOD PRESSURE …… STROKES ……HEART DISEASE…….

For Women

We provide a full range of contraceptive services at the surgery.

What method do you use: injection/pill/cap/sheath/IUD Coil/sterilisation/vasectomy

Have you ever had a cervical smear? Yes/No If YES date ……

Have you ever had a hysterectomy? Yes/No If YES date……

Have you been pregnant Yes/No How many pregnancies…….. Number of Children ……

Miscarriages ……. Terminations ……..

CHILDREN: To enable us to have an accurate immunisation history please bring your childs **red book** with you when you register.

Thank you for completing this questionnaire, it provides the Practice with valuable information and helps us to help you.

If you would like a **new patient check** with one of our Practice Nurses, to help us to identify any potential health problems early or information to help you stop smoking, lose weight, reduce alcohol intake etc. Please contact the surgery and arrange an appointment.

Thank you.

I have read the Practice Leaflet and agree to comply with the services offered to me.

Patient Signature …… **Date** ……

For up to date surgery news and other medical information:

Visit our website: www.alchestermedicalgroup.co.uk Like us on Facebook: @AlchesterMedicalGroup

Follow us on Twitter: @AlchesterMed

HOW WOULD YOU DESCRIBE YOUR ETHNICITY? (This questionnaire follows the recommendations of the Equality and Human Rights Commission and complies with the Equality Act 2010)

White
- ☐ British
- ☐ Irish
- ☐ Other White Background

Black/Black British
- ☐ Caribbean
- ☐ African
- ☐ Any Other Black Background

Asian/Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Other Asian Background

Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Other Mixed Background

Chinese/Other Ethnic Group
- ☐ Chinese
- ☐ Any Other Ethnic Group

☐ **Ethnic Status declined**

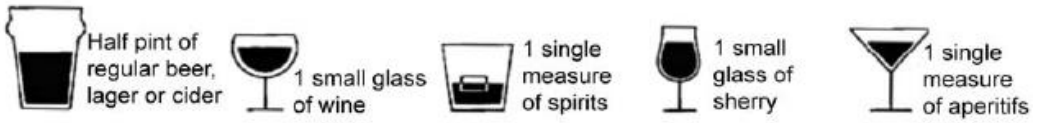
NATIONALITY ……..

SPOKEN LANGUAGE ……..

INTERPRETER REQUIRED **YES** **NO**

ALCOHOL Please complete the following if you are 16 years or older.

This is one unit of alcohol…



…and each of these is more than one unit

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Less than 7= Low Risk 7 – 15 =Increasing Risk Higher than 15 = High Risk