Please fill in the details requested in this questionnaire as fully as possible and return to the Practice with your registration documents. We need this form in order to complete your registration.

**STRAND MEDICAL**

**NEW PATIENT QUESTIONNAIRE AGE OVER 16**

If you are taking medication regularly, please bring the prescription tear-off slip or a list of your medications from your previous Practice when you return this form. The GP may need to see you to review your medication.

If required, an initial appointment with a clinician can be arranged on joining the Practice.

**PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| SURNAME: |  | FIRST NAME: |  |
| DATE OF BIRTH: |  |  | FEMALE: |  | MALE: |  |
| MAIN LANGUAGE: |   | ETHNICITY:  |  |
| OCCUPATION: |  |

|  |  |
| --- | --- |
| ADDRESS: |  |
|  |  | POST CODE: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TELEPHONE HOME: |  | WORK: |  |
| MOBILE: |  |  |
| EMAIL ADDRESS: |  |

Occasionally it may be necessary for the surgery to contact you by telephone, for example to change an appointment. If you are not available to take the call, may we leave a message with a third party, on answer phone or on voicemail? No medical information would be given or disclosed. Please specify as applicable:

|  |  |  |  |
| --- | --- | --- | --- |
| I give permission for the surgery to leave a message:\*  | With a third party | Home number | Mobile voicemail |
| *\* Please circle all relevant* |  |
| I give permission for the surgery to text to my mobile:  | YES: |  | NO: |  |
| Please note that consent to all the above will be assumed if no options are marked.This arrangement will remain in force until you advise us in writing that you wish to change it. |

|  |
| --- |
| I **do / do not** (*delete as applicable*) consent to having a Summary Care Record. If no option is chosen, the default option will be that we will not create a record for you. For further details on the Summary Care Record, please see NHS Choices website at: <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/overview.aspx>  |
| Are you a Carer? | YES: |  | NO: |  |
| If yes, please give details of the person you care for:  |  |
| Do you have a carer? | YES: |  | NO: |  |
| If yes, please give details of the person who cares for you:  |  |
|  |

|  |  |
| --- | --- |
| Nominated Pharmacy for electronic prescribing: |  |

If you do not always collect your own prescriptions the Practice requires your consent for prescriptions to be collected by a third party (relative, carer, etc.). Please tick all that apply.

I give permission for my prescription to be collected by a third party:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Family member |  | Neighbour |  | Pharmacy |  | Other |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you allergic to any medicines? | YES: |  | NO: |  |
| If yes, please specify: |  |
| Are you allergic to anything else? | YES: |  | NO: |  |
| If yes, please specify: |  |

**LIFE STYLE QUESTIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Height: |  | Weight: |  | Waist circumference: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you smoke? | YES: |  | Never smoked: |  | Ex-smoker: |  | Years ago: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Monthly | 2 – 4 times per month | 2 – 3 times per week | 4 or more times per week |
| How often do you have a drink containing Alcohol? |  |  |  |  |  |

|  |  |
| --- | --- |
| Please specify how many units on a typical day: | 1 unit = ½ of beer or 1 measure of spirits or 1 small glass of wine |
| 1 – 2  |  | 3 – 6  |  | 7 – 9  |  | more than 9  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Less than monthly | Monthly | Weekly | Daily |
| 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? |  |  |  |  |  |
| How often during the past year have you found that you were not able to stop drinking once you had started? |  |  |  |  |  |
| How often during the past year have you failed to do what was normally expected of you because of drinking? |  |  |  |  |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? |  |  |  |  |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? |  |  |  |  |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? |  |  |  |  |  |
| Have you or somebody else been injured as a result of your drinking? |  |  |  |  |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Signature: |  | Date: |  |

Thank you for taking the time to complete this questionnaire.