



If you would like a new patient medical please book an appointment at the reception desk.
If you do not wish to have a new patient medical please tick this box *NPM declined*

FULL NAME								
ADDRESS								
DATE OF BIRTH		ETHNIC GROUP		MAIN SPOKEN LANGUAGE		GENDER		
HEIGHT		WEIGHT		HOME TELEPHONE NUMBER		MOBILE NUMBER		
I give consent to receive appointment and other reminders via SMS message from the practice							YES	NO
EMAIL ADDRESS								
Would you like us to email you an electronic copy of our quarterly patient newsletter?							YES	NO
Are you interested in finding out more information about our Patient Participation Group (PPG) which gives you the opportunity to become more involved with the surgery by putting forward your ideas and suggestions for ways we can improve our services, as well as keeping you up to date with the latest surgery news?							YES	NO

Question	NO	YES	
Do you already have a nominated pharmacy for the Electronic Prescription Service (EPS)?			Name and address of current nominated pharmacy.
Are you allergic to any medications?			If yes, please specify.
Are you a carer for a friend or relative or in receipt of carers allowance?			Who do you care for?
Do you have a carer?			Who cares for you?
Are you a current smoker?			How many cigarettes do you smoke a day?
Have you ever smoked?			In what year did you stop smoking?
Do you have any communication needs that you feel we need to be aware of?			If yes, please specify.

We invite all of our patients with long term health conditions to come for review with our practice nurses. It would be helpful if you could let us know by ticking the relevant boxes below if you currently have any of the following conditions.

Asthma	COPD	Diabetes Type 1 / Type 2	History of heart disease Eg heart attack	History of Stroke / TIA	Hypertension

How much exercise do you get?	None	Light	Moderate	Heavy
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ALCOHOL USERS TEST

Please circle the answer that applies to you for each question.

Questions	0	1	2	3	4
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
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+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Please tick the appropriate boxes if your immediate family have had any of the conditions listed below.

	Mother	Father	Sibling
Asthma			
COPD			
Diabetes			
Heart attack whilst under the age of 60			
Heart attack whilst over the age of 60			
Hypertension			
Stroke whilst under the age of 60			
Stroke whilst over the age of 60			
Thyroid problem			
Cancer			

Females only:

Question	YES	NO	If yes, please specify
Are you currently pregnant?			How many weeks? What is your due date?
Have you had a hysterectomy?			
If you are between 24 and 65 have you had a cervical smear?			How long ago did you have your last smear?

What method of contraception do you use? Please tick.

Oral contraceptive pill		Name of pill?
Contraceptive injection		Date of last injection?
IUD or Mirena coil		Month and year inserted?
Other		Please specify.
None		

Signed..... Date.....

If you have completed this questionnaire on behalf of somebody else please specify your name and relationship to the patient:

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THANK YOU