WAREHAM SURGERY: NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire as fully as possible **on both sides**. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It can take several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

When you have completed the form, please return it to the receptionist. This information will be held in your personal health record which, like all NHS records, remains confidential. For further details about your health records, please see our patient information leaflet.

If you have any other health concerns, please discuss them with a nurse or GP.

PERSONAL DETAILS	
Surname:	**First name(s):**
Previous surname(s):	**Sex:** Male/Female **Title:** Mr/Mrs/Miss/Ms/Dr/Other
Date of birth:	**Occupation:**
Home address:	
Home tel:	**Mobile tel:** **Do you consent to us contacting you by SMS text message?** YES/NO
Work tel:	**Email:** **Do you consent to us contacting you by email?** YES/NO

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT				
Telephone: Mobile/Home/Work	Email	SMS	Letter	

SUMMARY CARE RECORD

The Summary Care Record allows other NHS Healthcare workers to see your current medication, the allergies you suffer from and any bad reactions to medicines you have had that are recorded in your medical record. No other information is released without your express consent. **Do you consent to a Summary Care Record?** YES/NO

YOUR DATA MATTERS TO THE NHS

Information about your health and care helps us to improve your individual care, speed up diagnosis, plan local services and research new treatments. If you would like to opt out of sharing your confidential patient information for research and planning, visit nhs.uk/your-nhs-data-matters or call 0300 303 5678

Wareham Surgery is research active, you might be asked to take part in a clinical research study. Taking part is voluntary and can be a rewarding experience.

☐ **Yes** – I consent to Wareham Surgery contacting me regarding relevant research studies

☐ **No** – I do not consent to Wareham Surgery contacting me regarding relevant research studies

NEXT OF KIN	
Name:	**Telephone:**
Relationship:	

CARERS

Do you look after or support someone who is ill, frail, disabled or mentally ill? YES/NO

Are you looked after or supported by somebody because you are ill, frail, disabled or mentally ill? YES/NO

If you answered 'yes' to either of these questions, please ask the receptionist for our carers form.

CHILDREN UNDER 18

Name of school:

Name of responsible adult: (*responsible adult is the natural mother or parents if married at time of birth, or an individual given legal custody)*

MILITARY VETERANS (please tick if applicable)	
History relating to Military Service	History relating to Navy Service
History relating to Army Service	History relating to Air Force Service

HEALTH INFORMATION		
Height:	**Weight:**	**Do you smoke?** YES/NO Cigarettes/cigars/pipe/roll-ups
If yes, how many per day?	**Have you ever smoked?** YES/NO	**If you have stopped smoking, give approximate date you stopped:**

We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please contact 0800 00 76653 or visit www.dorsetsmokestop.co.uk *This service can include assessment for drug treatment in the form of nicotine replacement, or alternative medication which may improve your chances of successfully quitting.*

Do you have any allergies? animals/pollen/nuts/medication/other (please specify)

Have you ever suffered from a bad reaction to any medication? YES/NO
If yes, please give details:

What medication do you currently take? (include both prescription and over the counter, please attach a previous repeat medication slip if you have one):

Do you drink alcohol? YES/NO If yes, please answer the following questions – please circle the appropriate response

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
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 failed to do what was normally expected from you because of your drinking?	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
How often during the last year have you been unable to remember what happened the night before because you had been 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 the last year		Yes, during the last year
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year

PERSONAL & FAMILY MEDICAL HISTORY

Please give details of any serious illness, accident or special needs, including dates:

Have any close relatives (parents, brothers, sisters or children) suffered from any of the following or died before the age of 65? Please specify the disease and their relationship to you.
Heart disease (heart attacks/angina)?
Stroke?
Cancer?
Other?

ETHNIC ORIGIN

Please indicate your ethnic category. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions:

MAIN SPOKEN LANGUAGE

Please state your main spoken language:

ACCESSIBLE INFORMATION STANDARDS

Do you have any information or communication needs that we should know about?