Victoria SURGERY

Welcome to our practice. Please take a few minutes to complete this new patient questionnaire to provide us with some information about you whilst we wait for your medical records to be sent from your previous surgery.

In order for your registration to be completed we would need to see the following items:
Proof of address i.e. Utility Bill
Passport/Photo ID

Full Name	
Address	
Date of Birth	
Home Tel No	
Mobile No	
Email Address	

Ethnic Group		Language Spoken		Interpreter Required	Y/N
Height		Weight		Marital Status	

Question	Yes	No	If yes, please specify
Are you currently taking any prescribed tablets, medications or inhalers? (Please provide a current prescription list from your surgery with this form)			
Do you already have a nominated pharmacy for the Electronic Prescription Service (EPS)?			Name and address of current nominated pharmacy
Do you have any allergies to any medications that you are aware of?			
Are you currently attending your doctor's surgery for regular check-ups or for a current problem?			
Are you are 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 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?			

Please Turn Over

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 if you currently have any of the following conditions:

Asthma	COPD	Diabetes Type 1/Type 2	History of heart disease i.e. Heart Attack	History of Stroke or TIA	Hypertension

Alcohol Users Test

Please circle one box for each question that applies to you.

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?			
Have you had a hysterectomy?			
If you are between 24 and 65 have you had a cervical smear?			

What method of contraception do you use? Please tick

Oral Contraceptive		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:

…….