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:
one Proof of address i.e. Utility Bill and one Passport/Photo ID

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 or email from the practice				YES	NO
EMAIL ADDRESS					

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 if you currently have any of the following condition

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

PLEASE TURN OVER

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?			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