THORNE MOOR MEDICAL PRACTICE

Partners: Dr J Firth, Dr M Abraham, Dr E Okeke

QUESTIONNAIRE FOR NEW PATIENTS

As your medical records may not arrive for some time, it would be helpful if you could complete the following questionnaire to provide us with some baseline information. When your notes arrive, you will be called for a health check up – though patients with an immediate health need will be given priority.
If you have a problem with your health which you need to discuss before your notes arrive, please make an appointment to see the GP.
Please complete both sides of the form. All information will be held in confidence.
Return to our Moorends branch at The Orchard Centre with proof of identification eg: Drivers Licence, Passport, and proof of address eg: Utilities Bill, Bank Statement (must have your name included).

Name _____ **Date of Birth** _____

Address _____

Occupation (or school if under 16) _____ **Home Tel no** _____

Mobile no _____ **Email:** _____

Do you have any of the following conditions?		**Comments**
Asthma.	Yes / No	
Chronic Obstructive Pulmonary Disease (COPD)?	Yes / No	
Diabetes Mellitus?	Yes / No	
Heart problems?	Yes / No	
Depression?	Yes / No	
Mental Health problems?	Yes / No	
Learning Difficulties?	Yes / No	
Epilepsy?	Yes / No	
Thyroid problems?	Yes / No	
Blood Pressure problems?	Yes / No	
Problems with your eyesight?	Yes / No	
Problems with your hearing?	Yes / No	
Any other long-term problems? Please give details	Yes / No	
Have you served in any of the Armed Forces?	Yes / No	
Do you have anything you would like to discuss with the GP as soon as your notes arrive? If so, please give details.	Yes / No	
Do you have any allergies? (If so, please specify	Yes / No	
Have you had a flu injection this year?	Yes / No	
Are you a smoker?	Yes / No	If yes, how many per day?
Are you an unpaid carer for family or friend?	Yes / No	If yes, for whom do you care?

Text Messages: If, on the mobile number above, you do <u>not</u> want to receive TEXT reminders about appointments and occasional information about talks and meetings at the surgery please sign in the box

Please turn over

PRESCRIPTIONS Please list any tablets or medications you are currently taking including, for women, the contraceptive pill. Alternatively attach the repeat medication slip from your previous GP.

Your Summary Care Record is a list of your medication and allergies, and it is stored on the secure NHS national database. This could be useful if, for example, you ever fall ill somewhere else in the country because the doctor treating you would know what medication you're already on and what you're allergic to. (It contains no other details about you except your name, address, date of birth and NHS number.) If you don't want this information to be stored on the national database, please ask us for an opt-out form. You can opt back in at any time.

ETHNICITY

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.
Please indicate your ethnic origin. 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. Choose ONE section from A to F, and then tick ONE box to indicate your background.

A ✓ White

	British
	Irish
	Any other white background? Please write here…

B ✓ Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background? Please write here…

C ✓ Asian or Asian British

	British Asian
	Indian or British Indian
	Pakistani or British Pakistani
	Any other Asian background? Please write here:

D ✓ Black or Black British

	Black British
	Caribbean
	African
	Any other black background? Please write here:

E ✓ Chinese Other Ethnic Group

	Chinese
	Any other black background? Please write here:

F ✓ Ethnicity not declared

	I prefer not to declare my ethnicity.

First Language

English		Other – please tell us here:

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QUESTIONNAIRE ON ALCOHOL INTAKE

Your Name: ……

There is increasing evidence that alcohol influences our health. Sensible drinking can have a positive effect, but it is very easy for alcohol consumption to increase to riskier levels.

As a new patient registering at Thorne Moor Medical Practice we would find it helpful if you could fill in the attached questionnaire as honestly as possible. It may be appropriate to discuss your answers with your GP when you attend the surgery for your New Patient Check-up.

Please complete both sides of this form by circling the relevant boxes. All information will be held in confidence.

1. How often do you have an alcoholic drink?

0		1		2		3		4	
Never		Monthly or less		2-4 times per month		2-3 times per week		4 or more times per week	

No need to go further. Please return this questionnaire to the surgery.

Please answer the next two questions

2. How many drinks of alcohol do you have on a typical day?

0		1		2		3		4	
1 or 2		3 or 4		5 or 6		7 or 8		10 or more	

3. How often do you have 5 or more drinks on one occasion?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

Please turn over for some more questions.

For Office Use		**+**		**=**	

4. How often during the last year have you found that you were unable to stop drinking once you had started?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

5. How often during the last year have you failed to do what is normally expected from you because of drinking?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy session?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0		1		2		3		4	
Never		Less than monthly		Monthly		Weekly		Daily or most days	

9. Have you or someone else been injured as a result of you drinking?

0		2		4	
No		Yes, but not in the last year		Yes, during the last year	

10. Has a relative, friend, Doctor or other health worker been concerned about your drinking or suggested you cut down?

0		2		4	
No		Yes, but not in the last year		Yes, during the last year	