Updated 23 3 2015 by Paula Stones

Checked by:

THE CROOKES PRACTICE

NEW PATIENT QUESTIONNAIRE – you must complete and return with your registration form to complete your registration at the practice.

FOR UNDER 16'S WE REQUIRE A VACCINATION HISTORY. PLEASE ATTACH TO THIS FORM.

TITLE _____ NAME _____ Date of Birth _____

Mobile phone no: _____ E-mail _____

Height _____Weight_____ Occupation _____

Are you allergic to any medication? Yes/No Other allergies Yes/No
If yes – please state which _____ If yes please state _____

Do you smoke? Never Ex-smoker Current smoker If current, how many per day?
_____

If yes do you require help with stopping smoking? Yes/No

Female Patients
Do you use contraception? Yes/No If yes please state type _____

Date of last smear test, if applicable _____

Personal & Family History

Do you have any of the following?

Heart problems (such as Heart Attack) Diabetes Cancer Asthma Blood Clots High Cholesterol Stroke before the age of 65 yrs Thyroid Disease

If yes, please give brief details_____

Do you have any family history of the following?

Heart problems (such as Heart Attack) Diabetes Cancer Asthma Blood Clots High Cholesterol Stroke before the age of 65 yrs Thyroid Disease

If yes, please give brief details, if possible of age, type of cancer - if known - and relationship to you.

_____
_____

Any known inherited/genetic diseases _____

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Do you look after someone, Other than a child? Yes/No Are you a registered carer? Yes/No

Does someone look after you? Yes/No

Ethnicity

* I would describe my ethnic origin as follows:		
Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background **Black or Black British** ☐ African ☐ Caribbean ☐ Any other Black background	**Mixed** ☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐ Any other mixed background **White** ☐ British ☐ Irish ☐ Any other White background	**Other Ethnic Group** ☐ Chinese ☐ Any other ethnic group ☐ I do not wish to disclose my ethnic origin

What is your first language? _____ Do you speak English? _____

Do you want to make an appointment for a new patient health check? If so please contact the surgery when your registration has been processed.

REGISTRATION WILL TAKE 2 WORKING DAYS – YOU WILL NOT BE ABLE TO BOOK AN APPOINTMENT UNTIL AFTER THIS TIME.

IF YOU REQUIRE REPEAT PRESCRIPTIONS – PLEASE MAKE AN APPOINTMENT WITH THE DOCTOR AND BRING ALL YOUR MEDICATION DETAILS WITH YOU.

****If you are registered for Electronic prescribing you need to make sure that you contact the chemist you want your scripts to go to so they can change your nomination for you. If you don't do this they will continue to go to your previous chemist. ****

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PLEASE NOW COMPLETE THE ATTACHED LIFESTYLE QUESTIONNAIRE

Please take care to complete this section as accurately as possible. Put a tick in the box which most suits your lifestyle

How often do you have a drink that contains alcohol?	Never **0**	Monthly or less **1**	2-4 times a month **2**	2-3 times a week **3**	4+ times a week **4**
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2 **0**	3-4 **1**	5-6 **2**	7-9 **3**	10+ **4**
How often do you have 6 or more standard drinks on one occasion?	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
TOTAL SCORE (add together the figures in bold)					

If you have a total score of 5 or more, please complete the next section

During the past year, how often have you found that you were not able to stop drinking once you've started	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
During the past year, how often have you failed to do what was normally expected of you because of drinking	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
During the past year, how often have you needed a drink in the morning to get yourself going?	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
During the past year, how often have you had a feeling of guilt or regret after drinking?	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
During the past year, have you ever been unable to remember what happened the night before because you had been drinking?	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
Have you or someone else been injured as a result of your drinking?	No **0**	Yes, but not in the past year **2**	Yes, during the past year **4**		
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No **0**	Yes, but not in the past year **2**	Yes, during the past year **4**		

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PATIENT CARE TEXT MESSAGING

CONSENT FORM

DECLARATION

We have a text messaging service, to be included in this service we require your consent and up to date mobile number.

Please note that due to confidentiality reasons we can only text to the phone of individual patients and not to those of a partner or parent unless we have express permission from the patient. **This facility will not be available for children under the age of 16.** If you would like to receive SMS messages for your children please give your mobile number.

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time and I understand that the surgery does not offer a reply facility to enable patients to respond to texts directly.

Patient name: …… Date of birth:…….

Address:
…….

……
…….

Mobile telephone number:……. Date of consent: ……..

Registration for Online Services

Our internet services allow you to book and cancel appointments online and order prescriptions.

To register for this service we require an up to date email address and proof of identity.

Please note that due to confidentiality reasons we can only send email confirmation to the email address of individual patients and not to anyone else unless we have express written permission from the patient.

Please ask one of our receptionists to register you for this service once your practice registration has been processed.