27 BEAUMONT STREET MEDICAL PRACTICE **Confidential**

New Patient Questionnaire

Welcome to 27 Beaumont Street Medical Practice. Please help us by filling in this questionnaire as it may take some time for your previous records to reach us. The information you give will be used to provide you with the best possible medical care.

Personal details : Date of registration …….....

Mr/Mrs/Miss/Ms……..First Names…….……..Surname…….……..

Address…….. ……..…….

Post code……Date of birth …….. ….Occupation ……

Email Address ……Tel No…….……Mobile ……..

Next of Kin details Mr/Mrs/Miss/Ms……Full Name……..

Address……..…….…….…….

Relationship to you……Tel No…….……Mobile …….

PLEASE NOTE THAT WE USE TEXT MESSAGING AND EMAILING FOR RECALLS AND APPOINTMENT REMINDERS - IF YOU DO NOT WISH US TO CONTACT YOU IN THIS WAY PLEASE TELL A RECEPTIONIST.

Lifestyle Height …… Weight……..

Are you a smoker? **Yes / No** If Yes, would you like the practice nurse to contact you to discuss smoking cessation **Yes please / No thanks**	If No, Have you ever smoked? **Yes / No** If Yes when did you stop smoking? ……

ALCOHOL - Please answer the following questions :

	Scoring System				
Questions	**0**	**1**	**2**	**3**	**4**
1. 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
2. How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
3. How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
If your score for Q1-3 is 5 or more please complete the questions on page 3					

Past medical history

Please give details of any important illness, operations or of pregnancies :

Month……Year…….Details……..

Month……Year…….Details…….…….

Month……Year…….Details…….…….

Drugs & Treatment

If you are taking any drugs or treatment, please detail below :

Name of medicine ……Strength……..…..Dose/day……

Name of medicine…….Strength……...Dose/day……

Name of medicine…….Strength……...Dose/day……

Have any medicines ever disagreed with you? YES?NO
If yes, which ones? …… ..

Do you have any allergies? YES/NO
If yes, please detail ……..

Family History

Have any close family members suffered from *(please state family member & whether paternal or maternal)*
ASTHMA……..….HIGHCHOLESTEROL…..……..……

DIABETES…….STROKE..……

CANCER (Please specify)…….

HEART TROUBLE……... HIGH BLOOD PRESSURE ……..……..

Do you care for a chronically sick or disabled friend or relative? YES / NO

If YES, who do you care for? …….

Immunisations

ADULTS: Have you had a course of tetanus injections/tetanus boosters in the last 10 years? YES/NO

CHILDREN : Dates of immunisations : DTP(1st) ……...2nd)…..……(3rd…….…MMR……..…
Pre-School……

Women
Date of last cervical smear…….. Result of smear…….
Was it taken by your GP ☐ Privately ☐ Hospital ☐ Abroad ☐ *(please tick)*

Ethnicity *(using codes below)*…….… First Language……..

White	Asian or Asian British	Other Ethnic Group
A. British	H. Indian	R. Chinese
B. Irish	J. Pakistani	S. Any other Ethnic Group
C. Other	K. Bangadeshi	Z Not stated
	L. Any other Asian	

Mixed	Black or Black British
D.White & Black Caribbean	M. Caribbean
E. White & Black African	N. African
F. White & Asian	P. Any other Black background
G. Any other mixed background	

Have you ever been a member of the armed forces? Yes/No

Name ……..

Further Alcohol questions – ONLY to be completed if your score for the alcohol questions on page one is 5 or more.

Alcohol Screening – Audit Total Score for Q 1 – 3 =

	Scoring System					
Questions	**0**	**1**	**2**	**3**	**4**	**Score**
4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often in the last year have you had a feeling of guilt or regret after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes, during the last year	
10. Has a relative/friend/ doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes but not in the last year		Yes, during the last year	
					Total score for <u>ALL</u> questions (1-10)	

Accountable/Named GP for <u>All</u> patients

The practice is required by the Government under the terms of the latest GP contract to allocate all patients a named accountable GP.

Having a named GP does not prevent you seeing any other doctor in the practice. Your accountable GP is the doctor you are registered with. If you wish to be told the name of your accountable GP please ask a receptionist.