

This questionnaire has been designed to help us care for your health whilst your records are being forwarded from your previous doctor. Please read the questions and complete where appropriate. This information will remain entirely confidential.

Would you like your prescriptions to be sent automatically to the pharmacy of your choice? Yes No

If **Yes**, please state the name and address of your chosen pharmacy

.....

.....

Would you like to register for online services? Yes No

(booking/cancelling appointments, ordering prescriptions, access to certain aspects of your medical record)

If **Yes**, please state your email address. A login and password will be emailed to you

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From time to time we will send out important information about the surgery via email, including our quarterly patient newsletter. If you **do not** wish to receive such information by email, please tick this box

Any other information you wish to share

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General Information

Name Date of birth

Phone Number Mobile Phone no.

Email Consent to text messages? Yes No

Next of Kin Information (Parent / Guardian Information if you are registering a child)

Name Date of birth

Phone Number Address

Relationship

Ethnicity

White British <input type="checkbox"/>	Black African <input type="checkbox"/>	Chinese <input type="checkbox"/>
Other White British <input type="checkbox"/>	Black Other <input type="checkbox"/>	Traveller <input type="checkbox"/>
White Other <input type="checkbox"/>	Indian <input type="checkbox"/>	Other (Please state below) <input type="checkbox"/>
Black British <input type="checkbox"/>	Pakistani <input type="checkbox"/> <input type="checkbox"/>
Black Caribbean <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	

Please state your first language:

Please state any religious or cultural needs

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Armed Forces Veteran

Please indicate if you are an Armed Forces Veteran as we may require more information from you

Are you taking any medication?

If **Yes**, please indicate

Do you have any allergies or sensitivities?

If **Yes**, please indicate

Carer

Do you have a carer? If so, please provide their details:	Are you a carer for a relative, friend or neighbour?
.....	Yes No

Memory

Do you have any concerns regarding your memory? Yes No

If **Yes**, please arrange to see a GP or Practice Nurse

Personal & Family Medical History

Please tick whether you have any of the following, or state the familial relationship and give more details on the diagnosis (*e.g. lung cancer*)

Heart Attack

Diabetes

High Blood Pressure

Cancer

Stroke

Mental Illness

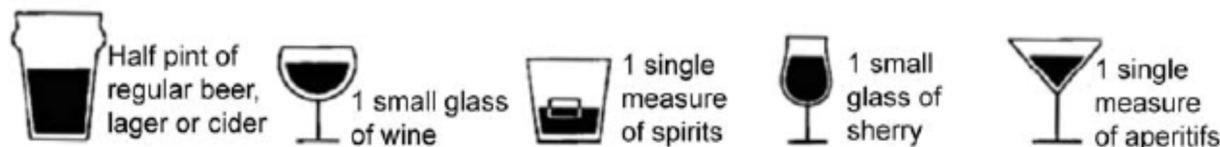
Asthma

Epilepsy / Fits

Alcohol Consumption

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

This is ONE unit of alcohol...



Smoking

Do you smoke? Yes No

If **Yes**—how many cigarettes do you smoke a day?

If **No**—have you ever smoked? Yes No

If you have stopped smoking, when did you stop?

Communication/Sensory Needs

Do you have any specific communication/sensory needs? (*e.g. hearing or visual loss, other disability affecting receiving and understanding information*)

Using British sign language

Uses sign language

Does use hearing aid

Using lip-reading

Uses deafblind intervener

Uses communication device

Uses speech to text reporter

Uses lipspeaker

Uses cued speech transliterator

Uses a legal advocate

Uses manual note taker

If **YES**, then please state if you have a preferred method of communication? (*e.g. prefer contact by telephone, letter, text. Or prefer information verbally, in small print or require an interpreter*)

Interpreter needed - British Sign Language

Hands-on signing interpreter needed

Requires information verbally

Requires information in Easyread

Requires contact by telephone

Requires contact by email

Requires contact by letter

Requires contact by SMS text message

Requires manual note taker

Sign Supported English interpreter needed

Requires lipspeaker

We will take your above preferences into account where possible in future contact

If English isn't your first language please tick here if you need an interpreter

Please specify which language.....

**Please return this document to Reception.
Thank you.**