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| **Brook Health Centre & Silverstone Surgery** **New Patient Questionnaire** |
| **PERSONAL DETAILS** |
| Full name |  |
| Date of birth |  |
| NHS number |  |
| Country of birth |  |
| Address |  |
| Postcode |  |
| Contact numbers | Home: Mobile: |
| Email address |  |
| First LanguageDo you need an interpreter? | Please state ……**………………………………………………………………**Yes No  |
| **\*Previous GP Surgery** | **……………………………………………………………………………………** |
|  |
| **CARER** |
| Do you have someone who looks after you? | Yes  No  | If *YES*, please tell us who looks after you? |
| Do you look after someone, elderly or disabled? | Yes  No  | If *YES*, please tell us who you look after? |
|  |  |
| **PRESCRIPTIONS** |
| Would you like us to send your prescriptions electronically to a local pharmacy? | Yes  No  |
| If *YES*, please indicate which pharmacy you would like | LLOYDS-BROOK HEALTH CENTRE (NEXT DOOR) |  |
| LLOYDS-WATLING STREET (TOWN CENTRE) |  |
| OTHER (PLEASE SPECIFY) |  |
| **If you live more than one mile from a pharmacy and would like to have your medication dispensed at our Silverstone Surgery, please tick here**  |  |
|  |
| **NEW PATIENT CHECK** |
| Would you like a New Patient Health check? | Yes  No  |

**Full name: …………………………………………**

**Date of Birth: ………………………………………**

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| **MEDICAL HISTORY** |
| How often do you drink?*Please tick appropriate box* | NEVER | MONTHLY OR LESS | 2-4 TIMES A MONTH | 2-3 TIMES A WEEK | 4+ TIMES A WEEK |
| How many standard alcoholic drinks do you have on a typical day?*Please tick appropriate box* | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |
| How often do you have 6 or more alcoholic drinks on one occasion?*Please tick appropriate box* | NEVER | MONTHLY OR LESS | MONTHLY | WEEKLY | DAILY ORALMOST DAILY |
| Do you CURRENTLY smoke cigarettes? | Yes  No  |
| Do you CURRENTLY smoke an e-cigarette? | Yes  No  |
| Have you given up smoking? | Yes  No  |
| If YES, when did you give up? |  |
| If NO would you like support from us to help you give up? | Yes  No  |
| Approximate height |  |
| Approximate weight |  |
| **Has anyone in your family had any of the following medical conditions?** | **Family member details** |  |
| **ASTHMA** |  |  |
| **DIABETES** |  |  |
| **HIGH BLOOD PRESSURE** |  |  |
| **HIGH CHOLESTEROL** |  |  |
| **HEART ATTACK** |  |  |
| **STROKE** |  |  |
| **CANCER** |  |  |
| **EPILEPSY** |  |  |
| **MENTAL HEALTH/ANXIETY/DEPRESSION** |  |  |
| **Please tell us about any medical condition that we need to know about yourself before your medical notes are transferred** |
| **Medical Conditions, if any** |  |
| **Allergies** |  |
|  |
| **MEDICATION** |
| **Are you currently on any repeat medication**\* If yes, please contact reception to make an appointment to speak to a clinician\* | Yes  No  |

**Full name: ……………………………………………….**

**Date of Birth: ……………………………………………**

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| **ETHNIC CATEGORY** |
| Please indicate your ethnic category below. This is designed to help you with your healthcare, as some health problems are more common in specific communities. This information will be added to your health record and will remain confidential. Choose ONE category and then tick the box to indicate your ethnic category. If asked to specify, please do so as fully as possible. |
| **White** | **Black or Black British** |
| British or Mixed British  | Caribbean  |
| Irish  | African  |
| Other white background (please specify)…………………………………………………. | Other black background  (please specify)…………………………………………………. |
| **Mixed** | **Asian or Asian British** |
| White and Black  | Indian  |
| White and Asian  | Asian  |
| Other Mixed background  (please specify)…………………………………………………. | Other Asian background (please specify)…………………………………………………. |
| **Other Ethnic Group** |  |
| Please specify: ………………………………………….…………………………………………………………….. |  |
|  |
| **NEXT OF KIN** |
| If you have a Next of Kin whose details you would like to add to your medical record, please complete the following: |
| **Full name:** |  |  |
| **Relationship:** |  |  |
| **Contact details:** |  |  |
|  |  |  |
| **SOCIAL WORKER** |  |  |
| Has a Social Worker ever been involved with you or your family?  | Yes  No  | If *YES*, please give further details |
|  |  |  |
| **MILITARY VETERAN** |  |  |
| Do you or have you ever served with the military forces? | Yes  No  | If *YES*, please give further details |
|  |
| **THANK YOU FOR COMPLETING THIS FORM** |
| **The information given will be treated confidentially and will form part of your medical record. The Practice is registered under the Data Protection Act.** |
| **I certify the above information is correct to the best of my knowledge. I confirm I will not register with more than one GP.** | **SIGNATURE****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DATE****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**FOR STAFF USE ONLY:**

Completed by: ……………………………………………………….

Date: …………………………………….