NEW PATIENT INFORMATION QUESTIONNAIRE
CONFIDENTIAL

To complete the registration process, ALL new patients are seen by the Healthcare Assistant for a New Patient Update

PLEASE WRITE IN BLOCK CAPITALS

PERSONAL INFORMATION

Gender: M / F
Mr / Mrs / Miss / Ms (*circle status*) Date of Birth: …………………………..............

First Names: ……………………………………... Surname: ………………………………………
Address: ………………………………………….
……………………………………………………
……………………………………………………
Telephone Number:
Home: ………………………………………… Mobile: ………………………………………

Please confirm you are happy for us to send you appointments reminders and other information relevant to your care by text message ***Yes / No***

Email Address: ……………………………………………………………………………………

Please confirm you are happy for us to send you relevant information by email ***Yes / No***

Occupation: ……………………………………
Next of Kin: ……………………………………... Relationship to patient……………………..
Telephone Number: ……………………………...

Other family members at this address
…………………………………………………………
…………………………………………………………
…………………………………………………………
…………………………………………………………
…………………………………………………………

SPECIAL CIRCUMSTANCES

Are there any special circumstances that you would like to bring to our attention? (e.g. social circumstances, housing concerns, etc) Yes / No
*If **Yes**, give details:*

Do you have a history of violence? Yes /NO
If Yes, *give details:*

Has anyone in the family been known to social care or had a Social Worker? Yes / No
If **Yes**, give details:

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LANGUAGE

Is English your first language? **Yes / No**
If **No** state language: ………..........................

COUNTRY OF ORIGIN ………………………………………………………………….

ETHNICITY

WHITE:
British / Irish / Greek Cypriot / Turkish / Kurdish
Other *please specify*: ……………………………

ASIAN or ASIAN BRITISH:
Indian / Pakistani / Bangladeshi / East African Asian
Other *please specify*: …………………................

BLACK:
Caribbean / African / Black British
Other *please specify*………………………………

MIXED:
White & Black Caribbean / White & Black African
White & Asian / Other *please specify*……………

CHINESE: Chinese / Other ethnic group: *please specify*:………………………………….

I would prefer not to answer [ ]

HEALTH

Your **Height**: Your **Weight**: Your **Blood Pressure**:
(Please use the patients' height/weight/BP machine in the waiting area)

Do you / or have you ever smoked?
Smoker / Never Smoked / Ex-smoker – date of quitting…………………………

FEMALE PATIENTS

Have you had a cervical smear? **Yes / No**
If **Yes, Year**:………………………**Result**: …………………………….....

Have you had a hysterectomy **Yes / No**
If **Yes, Year**: ……………………………….

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CARERS

Do you care for someone with a disability or illness? **Yes / No**

If you have a disability / illness:
Do you have a carer? **Yes / No/ Need One**

IMMUNISATIONS

If you are unsure whether your immunisations are up to date, please book an appointment for a consultation with a nurse.

CURRENT TREATMENTS/ILLNESSES

Long term lung disease	Y / N	……………….	Irregular heart beat	Y / N	…………..
Asthma	Y / N	……………….	Diabetes	Y / N	…………..
Heart Disease	Y / N	……………….	Liver disease	Y / N	…………..
High blood pressure	Y / N	……………….	Dementia	Y / N	…………..
Depression	Y / N	……………….	Mental Health Issues	Y / N	…………..

Are you under hospital treatment for any condition? **Yes / No**
If **Yes** give details…………………………………………………

Have you attended A&E in the last year **Yes / No**
If **Yes** give details……………………………………

Are you on any regular medication? ***Yes / No***
*If **Yes**, give details:………………………………...*

If you are on long term medication for any medical condition you will initially need to see a doctor to obtain a prescription.

DATE: ………………………………………...
NAME: ………………………………………..
SIGNATURE: ………………………………...

Staff use only:

Staff Initials…………………
Date…………………………
Named GP……………..
Patient address validated ☐
Audit C completed ☐
Audit completed ☐
Brief Intervention Leaflet Given ☐

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AUDIT – C

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	7-8	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	

Remaining AUDIT questions

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what has normally expected from you because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	