New Patient Questionnaire

Welcome to Neetside Surgery. Please take a few moments to fill out this questionnaire. The information we collect is **strictly confidential** and is used to ensure that we can provide the best care for you. It would help us greatly if you could fill in both sides. Thank you.

Dr Dowling, Dr Bloemertz, Dr Lucas and Dr Hadfield.

Name………………………………………….. DOB……..

Telephone No……………………………………. Mobile Number…………………………..

Next of Kin………………………Tel No……………… Relationship to patient……………...............

Occupation…………………………..Ethnic Origin…………………Height…………Weight………………

Prescriptions: My preferred chemist for prescriptions to be sent to is ……………………………………... (Dudley Taylor, Boots, Lloyds or Lloyds at Stratton) All above chemists use electronic prescribing (EPS) please tick box if you are happy to use this service ☐

Are you a carer for a relative, friend or neighbour? Y ☐ N☐
If yes, who do you care for?
………………………………………………………………………..
Are you being cared for by a relative, friend of neighbour? Y ☐ N☐
If yes, who is your carer?
…………………………………………………………………………
Do you or your carer have any information or communication needs relating to a disability, impairment or sensory loss? Y ☐ N☐
If yes, do you have any special requirements? (Larger writing, brail etc)
………………………………………………………………………………………………………

Please record current or previous major illness, health problems or operations
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……
……………………………………………………………………………………
………………………………………………………………………………………………………

Current medication (If you would like to provide a previous repeat prescription we can take a copy)
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Allergies………………………………………………………………………

Is there a close **family history** of any of the following illnesses? (Y/N)
Stroke………… High blood pressure…….…... Heart Disease…………… Diabetes………………………

What do you do for exercise and how often?
……
……
……

Smoking: Are you a smoker?.................................(Current, Ex or Never Smoked)

Current Smoker……………cigs/day Would you like help to stop? YES/NO
Ex Smoker………..cigs/day When did you stop?..........................

For Women Only:
Date of your last smear……………………………

What form of contraception do you use…………………

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 - 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	
					TOTAL	

(1 unit = 1 small glass of wine, half a pint of ordinary strength beer or a single measure of spirits)

Scoring:
If you score 5 or over please complete second part below

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 was 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	

TOTAL

Online Access – The Waiting Room

- Our online service allows patients over the age of 16 to:

  - Order prescriptions online

  - Book advance GP appointments

  - View their recorded allergies

- If you wish to register for this service we will need to see photographic ID and for you to provide us with an email address unique to you.

- Registering with The Waiting Room will also give you the ability to access other areas of your health record as the system develops.

If you wish to use this service please provide your email address below and bring along some photographic identification.

Email Address…………………………………………………………………

(Office use only: ID checked ☐ Initials………..)