Coastal Medical Partnership

OFFICE USE ONLY : PHOTO ID & ADDRESS ID REQUIRED
ID: Passport / Driving License / Utility Bill / Other
If other please specify: ………………………………
CHECKED BY: ………………………………………………
DATE: ………………………………

New Patient Questionnaire

Do you have any special communication needs? ☐ Yes ☐ No
If yes: ☐ Sign Language ☐ Large Print ☐ Other ………………………
Do you have a preferred Pharmacy? ………………………………………

Please answer all the questions:

Name:			
Address:			
Telephone(Home):		**Mobile Number:**	
Work Number:		**Email Address:**	
Date of Birth:		**Sex:**	**Male / Female**
Marital Status:		**No of Children:**	
Name of Next of Kin / Emergency Contact:		**NOK Telephone:** **NOK Mobile:**	
Relationship to you:			

Please measure your blood pressure on our machine beside the reception desk and hand the result to the receptionist with your completed questionnaire (adults over 30 only)

Please tick this box if you do not wish to give the following information:																
Ethnic Origin (Please tick the appropriate box):															**1st Language**	**English Speaker**
White/British		White/Other		Asian		Indian		Caribbean		Mixed		Other				Yes / No

1. Have you or a close relative ever suffered from the following?

	Details for You		Family History		Details for You		Family History
	Yes/No	Details	Yes/No		Yes/No	Details	Yes/No
Angina				**Epilepsy**			
Asthma				**Heart Attacks**			
Blindness				**High Blood Pressure**			
Glaucoma				**Removal of Spleen**			
Cancer				**Stroke/TIA**			
Diabetes				**TB**			
Eczema				**Pace-maker**			

1. Are you on any medication? Please give details:

Please turn over and complete page 2

2. Are you allergic to any medication or substances? Please give details:

3. Please list any operations you have undergone:

4. Please answer the following questions by circling the appropriate answer

How often do you have a drink containing alcohol?

Never (0)	Monthly or less (1)	Two to Four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	**Score**

How many units of alcohol do you have on a typical day when you are drinking?
(glass of wine or pint of beer = 2 units, measure of spirits = 1)

1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 or 8 (3)	10 or more (4)	**Score**

How often have you had six or more units if female, 8 or more if male, on a single occasion over the last year?

Never (0)	Less than monthly (1)	Monthly (2)	Weekly(3)	Daily or almost daily (4)	**Score**

5. Please answer the following questions

Are you
a smoker / ex-smoker / never smoked tobacco ? *Please delete as appropriate*

What do you smoke? *Cigarettes / pipe / cigars / roll your own*	
How many do you smoke per day?	

When did you stop smoking?	

6. For female patients only – Please answer the following question

Have you had a cervical smear? (yes / no)		Date:	
Are you pregnant?		Estimated delivery date	

The practice is introducing a mobile texting and e-mail communication service. This service may be used to send text & e-mail reminders to patients regarding upcoming appointments, requests to attend for repeat tests, speak to the doctor / nurse or book an appointment. We may also use this service to contact patients about health promotion.

Of course, this is subject to our usual confidentiality procedures. To help us maintain these, **it is important that you let us know if you change your mobile number or email address in the future.**

If you give consent for us to communicate with you by text messaging and/or e-mail as outlined above, please sign below. **If you decide you no longer wish to receive messages via this service, please inform us.**

Signed ………………………………………………………. Date ……………………………………………….

The Practice recommends that you book a New Patient Check with a Nurse or Healthcare Assistant. Please arrange this with reception. Thank you for completing this questionnaire.