

# FALLODON WAY MEDICAL CENTRE

## NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire as part as your registration and hand back to Receptionist.

<b>First Name:</b>  <b>Surname:</b>	<b>Smoking Status:</b>  I am a Smoker [ <input type="checkbox"/> ] I am an ex smoker [ <input type="checkbox"/> ] I have never smoked [ <input type="checkbox"/> ]  <i>(Please tick appropriately)</i>
<b>Date of Birth:</b>	<b>Occupation:</b>
<b>Title:</b> <i>(e.g. Mr, Mrs etc)</i>	<b>Allergies:</b>
<b>Landline number:</b>  <b>Mobile number:</b>  <i>We would like to text you appointment reminders, and if need be, request health information or prompt you to book clinical checks. Please <b>do not</b> give us a shared mobile number.</i>  <b>Text Messaging: YES / NO</b> <i>(Please select your preference)</i>  <b>Email address:</b>	
<b>Medication:</b>          <b>Significant medical history &amp; Current conditions:</b>          <b>Nominated pharmacy:</b>	
<b>Full name of next of kin:</b> <b>Relationship:</b> <b>Can we contact this person in the event of an emergency? YES / NO</b>	<b>Contact Tel No:</b>
<b>Carers</b> Do you look after someone who could not manage without you? <b>YES / NO</b> If yes, what is your relationship to this person?       Do you need/have anyone who looks after you or your daily needs as a Carer? <b>YES / NO</b> If 'Yes', would you like them to deal with your health affairs here? <b>YES / NO</b> The receptionist will be able to advise how to set this up <b>Full name of Carer:</b>   <b>Relationship: :</b> <b>Contact Tel No:</b>	

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**Ethnicity:**

*Optional (Please tick)*

White British	
White Irish	
Other white Background	
Mixed – White and Black Caribbean	
Mixed – White and Black African	
Mixed – White and Asian	
Other Mixed Background	
Indian	
Pakistani	
Bangladeshi	
Other Asian Background	
Caribbean	
African	
Other Black Background	
Chinese	
Other Ethnic Background	
Information Refused	

What is your first language?

Do you need an interpreter?

Do you need information in an accessible format

What is your religion? (Optional)

For aged 16 +, please complete the following:

**Please circle your answers to the following questions:**

	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

To enable us to check that you live within our practice area, you are required to produce proof of residency (e.g. utility bill or bank statement) dated within the last three months *and* photographic ID such as a passport or photocard driving licence. We cannot register you without sight of these documents.

For Office Use Only:

<p><b>ID CHECKS:</b> tick</p> <p>Passport [ ]</p> <p>Utility Bill [ ]</p> <p>Driving Licence [ ]</p> <p>Rent Book [ ]</p> <p>Work Permit [ ]</p> <p>Student Visa [ ]</p> <p>Bank Statement [ ]</p> <p>Other.....</p>	<p>Seen and approved by .....</p> <p><b>Additional Comments/Appointments Booked</b></p> <p>.....</p>
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