St Georges Medical Centre

New Patient Questionnaire

Your Details

Title		Home Address	
Surname			
First name(s)		Post Code	
Previous Surname(s)		Home Tel	
Date of Birth	DD / MM / YYYY	Mobile Tel	
Occupation		Work Tel	
Marital Status		Email	

Ethnicity

- ☐ White British
- ☐ Other White background
- ☐ Irish
- ☐ Other Asian background
- ☐ Black African
- ☐ Not stated
- ☐ Mixed White and Black Caribbean
- ☐ White and Asian
- ☐ White and Black African
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other Mixed background
- ☐ Asian or Asian British
- ☐ Indian Bangladeshi
- ☐ Black Caribbean Other Black background
- ☐ Other Ethnicity

If other, please state

Spoken Language

Religion

Next of Kin

Full Name		Home Address	
Relationship			
Home Tel		Post Code	
Mobile Tel			

Communication Needs

At St George's Medical Centre, we want to make sure that we are communicating with you in a way that is easy for you and that you can understand:

- We want to know if you need information in a specific format e.g. braille, large print or easy read
- We want to know if you need to receive information in a particular way e.g. electronically, via email, for use with a screen reader
- We want to know if you need someone to support you at appointments e.g. a sign language interpreter or an advocate
- We want to know if you lip-read or use a hearing aid or communication tool

Do you have any information or communication needs? Y ☐ N ☐

If so, how can we address these needs when communicating with you?

Medical History

Please list any serious illnesses / operations / accidents / disabilities and the year they took place:

Please list any medication you take at the moment:

Are you allergic to any medicines? If so, which ones?

Have you ever suffered from: (tick as appropriate)

- ☐ Eczema / Hay fever
- ☐ High blood pressure
- ☐ Heart Attack / Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ COPD
- ☐ Depression
- ☐ Asthma

	Y	N
Are you registered disabled?	☐	☐
Are you registered blind?	☐	☐
Are you registered partially sighted?	☐	☐

Family History

Do you have a family history of . . . (tick as appropriate)

- ☐ CVA
- ☐ High blood fat
- ☐ DVT/Thrombosis
- ☐ Asthma
- ☐ Glaucoma
- ☐ Hypertension
- ☐ CKD
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Breast Cancer

Any others, please state:

Smoking

	Y	N
Do you smoke?	☐	☐
If 'No', have you ever smoked?	☐	☐
Would you like advice on giving up smoking?	☐	☐

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per day?

Physical

What is your height? cm

What is your weight? kg

Blood pressure

Systolic mmHg

Diastolic mmHg

Alcohol

Alcohol Questionnaire AUDIT C (tick the relevant answer)

Q1 How often do you have a drink that contains alcohol?

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

Q2 How many standard alcoholic drinks do you have on a typical day when you are drinking?

1 or 2	(0 points)
3 or 4	(1 point)
5 or 6	(2 points)
7 to 9	(3 points)
10 or more	(4 points)

Q3 How often do you have 6 or more standard drinks on one occasion?

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

Total Score /12

What is a standard drink?

Half pint of regular beer, lager or cider

1 small glass of wine

1 single measure of spirits

If you scored OVER 5, please answer these questions

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Q4 How often in the last year have you found you were not able to stop drinking once you had started?	0	1	2	3	4
Q5 How often in the last year have you failed to do what was expected of you because of drinking?	0	1	2	3	4
Q6 How often in the last year have you needed an alcoholic drink in the morning to get you going?	0	1	2	3	4
Q7 How often in the last year have you had a feeling of guilt or regret after drinking?	0	1	2	3	4
Q8 How often in the last year have you not been able to remember what happened when drinking the night before?	0	1	2	3	4

	No	Yes, but not in the last year	Yes during the last year
Q9 How often in the last year have you or someone else been injured as a result of your drinking?	0	2	4
Q10 Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	0	2	4

Total Score (both sets of questions) /40

Women Only

Have you ever had a cervical smear? Y ☐ N ☐ If so, when?

Please List any current or previous pregnancies

Please list any children (including date of birth)

Patients aged 65 or over only

	Y	N	
Have you ever had a flu vaccination?	☐	☐	Date
Have you ever had a pneumococcal vaccination?	☐	☐	Date
Do you live alone?	☐	☐	
If yes, do you have help available?	☐	☐	

If you would like to receive a resource pack please tick here ☐

Carers

Do you have a carer? Y ☐ N ☐

Carer's Name

Carer's Address

Carer's Contact Tel

Are you a carer? Y ☐ N ☐

If yes for either, please give details

If you would like to receive a resource pack please tick here ☐

Signature **Date**

Office Use Only

Proof of identification provided? Y ☐ N ☐

Reference number

Type of ID (both photographic and proof of address)

Reference number

☐ Birth Certificate ☐ Drivers License ☐ Passport
☐ Utility Bill ☐ Allowance Book ☐ Solicitor's Letter
☐ Offer of Tenancy ☐ Other

	Y	N		Y	N		
Chronic disease	☐	☐	Appointment booked	☐	☐	Date / /	Time
Patient on current medication	☐	☐	Appointment booked	☐	☐	Date / /	Time
If none of the above, patient offered an appointment	☐	☐	Appointment booked	☐	☐	Date / /	Time
Information Services Form 2016-17 received	☐	☐	Named GP			☐ Informed of Named GP	

☐ Over 65 Resource Pack provided ☐ Carers Resource Pack provided Checked by ☐ Sue W ☐ Sue E ☐ Sally ☐ Jo