YOUR FAMILY HISTORY

If any of your immediate family were diagnosed with any of these illnesses **before the age of 60,** please tell us by ticking the appropriate box(es).

	Mother	Father	Sisters	Brothers
Asthma				
Diabetes				
Stroke/TIA				
Heart Disease				
High Blood Pressure				

What is your Ethnic Group?

The practice has been asked to request this information as part of the Department of Health's commitment to race equality. This information is not mandatory; however, it could be very important to the practice in assisting in diagnosis and identifying cause and prevalence of conditions which vary according to ethnicity. Please tick one box:

☐ White ☐ Black Caribbean ☐ Indian
☐ White British ☐ Black African ☐ Pakistani
☐ White Irish ☐ Other Black Background ☐ Bangladeshi

☐ Chinese ☐ Other Asian Background
☐ Other ethnic group ☐ **Do not wish to state ethnicity**

For Women aged 25+ only:

Date of last smear test: ___________ Where? _____________ Result:_____________

Working together

Thank you for your cooperation. We will review the information provided and contact you to offer health promotion advice or consultation if needed.

Please sign to acknowledge your understanding & agreement to use our services as set out in our Practice leaflet: ☐

Finally, our patient participation group (PPG) is a representative group of patients who actively review and contribute to the provision our services and facilities. If you would like to join, find out more from reception or our website www.wrmc.org.uk.

NEW PATIENT QUESTIONNAIRE

We need some information about you as soon as you register, as your medical records may take several weeks to arrive. Please answer each question as fully as you can. If you need any help filling in this sheet, please just ask one of our staff. This confidential information will be stored on our computer system and shared only for healthcare purposes.

Please return to: WRMC, 67 Washway Road, Sale, M33 7SS

Office use only: ID checked: Address checked: Rpt Rx info attached:

YOUR DETAILS **Date you completed this form:** ___________

Surname: ___________________ Forenames: _____________________

All Previous Surnames: ____

D.O.B:____________________ Title: __________________________

Address: ____

______________________________________ Postcode: ___________

Emergency contact name & number _______________________________

Your telephone no's (**including mobile**): ______________________

We offer automatic text reminders for appointments to your mobile number, please tick if you **do not** wish to receive this service **[ ]NO TXT** Messages

Email address:____

We will use your email address to send you quarterly newsletters or messages about your healthcare, please tick if you **do not** wish to receive this service **[ ] NO EMAIL**

Do you have any special information or communication needs? YES/NO

☐ Interpreter needed (state language)__________________________

☐ Other – eg: text relay service/SMS/email _____________________

Are you a carer? YES/NO **NB: Carers Support Worker @ WRMC Thursdays for advice**

(ie Are you responsible for the care of another adult/child with a disability)

Are you permanently housebound? YES/NO

YOUR CURRENT STATE OF HEALTH – please answer each question

Have you ever been diagnosed with:	No	Yes	Tick if you take regular medication for this*
Asthma			
Cancer			
COPD			
Depression			
Diabetes			
Epilepsy			
Glaucoma			
Heart disease			
Hypothyroidism			
High blood pressure			
Mental health			
Stroke/TIA			
Any other condition for which you take prescribed medication*			

***please attach a copy of your current re-order slip**

Were your prescriptions previously sent electronically to a pharmacy?

NO ☐

YES/NOT SURE ☐ please check with your previous surgery (if needed) then tick here ☐ to confirm you have contacted the pharmacy to remove your nomination [or future prescriptions will be sent directly there]

Do you suffer from any **allergies** or have had a reaction to any medication?

NO ☐ YES ☐ - please give details:

Please list any other serious or chronic illnesses, operations or disabilities:

____

____

____

____

____

LIFESTYLE HABITS – please circle or complete each section

Height (approx): ft ins **or** m

Weight *(approx): st lbs* ***or*** *kg*

Smoking Status:

☐ Never smoked tobacco

☐ Ex-smoker - I gave up in (year) ________

☐ Current Smoker - I currently smoke ________/day

ALCOHOL: Current alcohol intake in units = __________/week

[**1drink unit =** ½ pt Beer/lager/cider or small glass wine/sherry or 1 spirit measure]

It is currently a Department of Health priority for us to provide help and support to enable patients to drink within sensible limits. To help us do this, please circle your answers to the following 3 questions:

1. How often do you have a drink containing alcohol?

Scoring System					
0	**1**	**2**	**3**	**4**	**Your Score**
Never	Monthly or Less	2-4 times per month	2-3 times a week	4 + times per week	

2. How many units of alcohol do you drink on a typical day when you are drinking?

0	**1**	**2**	**3**	**4**	**Your Score**
1 - 2	3 – 4	5 – 6	7 – 8	10+	

3. 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?

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

A total score of 5+ indicates increasing or higher risk drinking. If this is the case, please make an appointment to see either our practice nurse, health-care assistant or a doctor for advice and support on sensible drinking or help in reducing your intake.