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				

If you have NO family history of the above, please tick the box ☐

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 & could be important 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 v1.1: ☐

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 when you register, as your medical records may take some time to arrive. **Please answer each question** as fully as you can. If you need help filling in this sheet, please just ask one of our staff. This confidential information will be stored electronically and shared only for healthcare purposes.

Please return this form to reception along with your GMS1 registration form, confirmation of ID & address & a list/re-order slip of repeat medication.

Office use only: ID checked: Address checked: Rpt Rx appt:

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 messaging for appointment & review reminders, please indicate your consent to this: [ ] **yes please**; no thanks [ ]

Email address:_____

We will use your email address to send you quarterly newsletters or messages about your healthcare, please indicate your consent to this: [ ] **yes please**; no thanks [ ]

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
(answer NO if caring is your paid employment only)

Are you <u>permanently</u> housebound? YES/NO
(ie unable to leave your home to attend appointments]

Are you a military veteran? YES/NO

YOUR CURRENT STATE OF HEALTH – please answer each line

Have you ever been diagnosed with:	No	Yes	Tick below if you are **currently** taking medication for this
Asthma			
Cancer			
COPD			
Depression			
Diabetes			
Epilepsy			
Glaucoma			
Heart disease			
Hypothyroidism			
High blood pressure			
Mental health			
Rheumatoid arthritis			
Stroke/TIA			
Any other condition for which you take prescribed medication* [including contraception]			Book appt with nurse before next supply needed

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

If you're currently taking prescribed medication, you will need to **book an appointment with our practice pharmacist in the next 5 – 10 days** & before you need your first prescription from us. We like patients to order their medication directly with us, online or in writing, so please bring formal photo ID to this appointment so we can set up online ordering for you.

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

Exercise: - read about our Thursday walking group at www.wrmc.org.uk
Number of times per week you engage in 30mins+ moderate activity? ☐

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

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

We can provide support to help patients drink within sensible limits. To help us do this, please circle your answers to the 3 questions below:

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're 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, healthcare assistant or a doctor for advice and support on sensible drinking or help in reducing your intake; view more info at www.nhs.uk/livewell/alcohol