5. The information below may be important in identifying cause & prevalence of conditions which vary according to ethnicity and ensuring services are shaped to best meet the individual needs of all our patients.

ETHNICITY

This information may be important in identifying cause & prevalence of conditions which vary according to ethnicity. Tick one box to indicate your ethnic group:

☐ White	☐ Black Caribbean	☐ Indian
☐ White British	☐ Black African	☐ Pakistani
☐ White Irish	☐ Other Black background	☐ Bangladeshi
☐ Other ethnic group		☐ Chinese
☐ Do not wish to state ethnicity	☐ Other Asian background	

GENDER

Which of the following options best describes how you think of yourself?

☐ Woman (including trans woman)	☐ Man (including trans man)	
☐ Non-binary	☐ In another way	☐ Don't want to say

Is your gender identity the same as the gender you were given at birth?

☐ Yes ☐ No ☐ Don't want to say

SEXUALITY

Which of the following options best describes how you think of yourself?

☐ Heterosexual/straight	☐ Gay or lesbian
☐ Bisexual	☐ Other sexual orientation not listed
☐ Not sure	☐ Don't want to say

6. For Women aged 25+ only:

Date of last smear test: _____ Where? _____ Result:_____

Working together Thank you; we will review the information provided and may contact you to provide 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 v1.2:

Signed:

NEW PATIENT QUESTIONNAIRE

We need some information about you now, 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, just ask one of our staff. This confidential information will be stored electronically & 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:

1. YOUR DETAILS

Date you completed this form: _____

Surname: _____ Forenames: _____

All Previous Surnames: _____ Title: _____

Address: _____

Postcode: _____ Date of birth: _____

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 [ ]

Emergency contact name & number _____

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

If interpreter needed, please state language:_____

State if other needs – e.g.: text relay service/SMS/email _____

Are you a carer? YES/NO
(i.e. do you care for a relative/partner/friend or disabled child on an unpaid basis)

Are you permanently housebound? YES/NO
(ie unable to leave your home to attend hospital or GP appointments]

Are you a military veteran? YES/NO

2. 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			

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

**** 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.

If you take prescribed Contraception, please book an appointment with our Practice Nurse before your next supply is needed.

Do you suffer from any **allergies** or have had a reaction to any medication?
NO ☐ YES ☐ - please list these here:

3. LIFESTYLE HABITS – please circle or complete each section

Height: ft ins **or** m **Weight**: 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]

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	

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+	

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

4. 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). If none, tick here ☐

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