Eden Villa Practice

We would like to collect some information about you and ask that you fill in the following questionnaire. This will enable

us to give you the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

|  |  |  |  |
| --- | --- | --- | --- |
| Title | Surname |  | First names |
| Date of Birth |  | Contact telephone numbers |
| Consent to leave voicemail [ ]  Yes [ ]  No |  | Email address |
|  |

**Additional details about you.**

|  |
| --- |
| What is your ethnic group? |
| **White****Black****Asian****Mixed****Other** | [ ] [ ] [ ] [ ] [ ]  | BritishCaribbeanIndianWhite + Black Caribbean*Please specify*: | [ ] [ ] [ ] [ ]  | IrishAfricanPakistaniWhite + African |  [ ]  [ ]  | ChineseWhite + Asian |

**Carer information**

|  |
| --- |
| Do you have a Carer? [ ] Yes [ ] NoIf yes, what is their name and contact number?Do you consent for your carer to be informed about your medical care? [ ] Yes [ ] No |

|  |
| --- |
| Are you a Carer? [ ] Yes [ ] NoIf yes, do you look after someone who is a patient of this practice? [ ] Yes [ ] No [ ]  Don’t knowIf yes, what is their name?Are they a: [ ] Relative [ ] Friend [ ] Neighbour |

**Next of kin**

|  |  |  |
| --- | --- | --- |
| Name of next of kin |  | Relationship to you |

|  |  |  |
| --- | --- | --- |
| Next of kin telephone number(s) |  | Next of kin address (if different to above) |

**Allergies**

|  |
| --- |
| \*Are you allergic to any medicines? [ ]  Yes [ ]  No (if yes please specify) |

|  |
| --- |
| \*List other allergies (pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of)  |

**Medication**

|  |
| --- |
| **Please provide a copy of your repeat prescription from your previous surgery; this will enable us to issue a prescription for your repeat medication.**  |

|  |
| --- |
| **Please record any additional information, for example any serious illnesses or recent operations**  |

**Have you ever had any of the following conditions?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | [ ]  Yes  | Year |  | **Mental Illness** | [ ]  Yes  | Year |
| **High Blood Pressure** | [ ]  Yes  | Year |  | **Diabetes** | [ ]  Yes  | Year |
| **Heart Attack / Angina** | [ ]  Yes  | Year |  | **Asthma** | [ ]  Yes  | Year |
| **Stroke / Mini-stroke (TIA)** | [ ]  Yes  | Year |  | **COPD**  | [ ]  Yes  | Year |
| **Cancer** | [ ]  Yes  | Year |  | **Osteoporosis / Bone fractures** | [ ]  Yes  | Year |
| **Rheumatoid Arthritis** | [ ]  Yes  | Year |  | **Peripheral vascular disease** | [ ]  Yes  | Year |

**Please tell us about your smoking habits**

|  |  |  |
| --- | --- | --- |
| Do you smoke? [ ]  Yes [ ]  NoIf Yes, what do you primarily smoke:Cigarettes / Cigar / Pipe (please circle) |  | Are you an ex-smoker [ ]  Yes [ ]  NoWhen did you quit?How many did you used to smoke a day? |
| How many do you smoke a day?Would you like advice on quitting? [ ]  Yes [ ]  No |  |  |

**Please tell us about your alcohol consumption. = 1 small glass of wine, I measure of spirit, ½ pint beer or lager**

|  |  |
| --- | --- |
| **Questions** (please circle your answers) | **Unit scoring system** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 timesPer month | 2 - 4 times per week | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? See chart below | 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 |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking alcohol? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last year have you failed to do what was normally expected of you because of drinking alcohol? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Has a relative or friend, a doctor or other health care worker been concerned about your drinking or suggested you cut down? | Never |  | Yes, but not in the last year |  | Yes, in the last year |

|  |  |  |
| --- | --- | --- |
| **Signature** |  | **Signed on behalf of patient** (*if applicable*)(e.g. for minors under 16 years old, adults lacking capacity) |

**On-line Services – Patient Access. – Two weeks after registration.**

 You will be able to register for our on-line services for access appointments, prescriptions and some sections of your own medical record via the internet. Please ask the receptionist for further details and a registration code.

**New Patient Health-check**

 You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant.  Contact reception if you should like to take this up.