St Paul’s Medical Centre – New Patient Questionnaire – Age 16+

Welcome to St Paul’s Medical Centre. Please complete this questionnaire clearly using **BLOCK CAPITALS**. Your information will be treated in strict confidence.

**Personal details: (It is VERY IMPORTANT you let us know as soon as possible if any of these details change in the future)**

NAME: …………………………………………………….……..… DATE OF BIRTH ……………………………………

HOME TEL No:…………………………………………………… MOBILE TEL No:……………………………………

E-MAIL: …………………………………………………………………………………………………..

**Tick here if you are NOT happy for us to send you information by Text [ ] or e-mail [ ]**

Have you ever been in the armed forces? YES [ ] NO [ ]

**ETHNIC GROUP (please tick one)**

White (British) [ ] Black or Black British (Caribbean) [ ]

White (Irish) [ ] Black or Black British (African) [ ]

White (Other) [ ] Black or Black British (Other) [ ]

Asian or Asian British (Indian) [ ] Asian or Asian British (Pakistani) [ ]

Asian or Asian British (Bangladeshi) [ ] Other Asian or Asian British [ ]

Mixed (white & black Caribbean) [ ] Mixed (white & black African) [ ]

Mixed (white & Asian) [ ] Mixed (white & other) [ ]

Chinese [ ] Other ethnic group [ ]

**FIRST LANGUAGE (please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any difficulty in speaking or understanding English? YES [ ] NO [ ]

**Next of kin:**

TITLE (Mr, Mrs, Ms) ……………………… NAME: ……………………………………………………………………..………..

ADDRESS: ……............……………………………………………………………………………………………………...……………

CONTACT TEL No: ……………………….. RELATIONSHIP TO YOU: ……………………………………………….

# **Disabilities & Health:** Please give details of any disabilities you have, relating to:

EYESIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you registered blind? YES [ ] NO [ ]

Do you need written information in LARGE FORMAT [ ] or BRAILLE [ ]

HEARING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use a hearing aid? YES [ ] NO [ ]

Do you need to use the LOOP SYSTEM when in surgery YES [ ] NO [ ]

LEARNING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need information in EASY READ format with pictures to help you? YES [ ] NO [ ]

Continued overleaf

Have your **mother, father, brother** or **sister** suffered from high blood pressure, heart problems, stroke or diabetes? If so, please state which disease(s) and which family member(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ladies** – Are you pregnant? No [ ] Yes [ ] What is your expected delivery date? \_\_\_\_\_\_\_

**Your lifestyle:**

Have you **ever** smoked tobacco? YES [ ] NO [ ]

Do you **currently** smoke tobacco? YES [ ] NO [ ] how many cigarettes per day? \_\_\_\_\_

Do other people regularly smoke near you? YES [ ] NO [ ] you may be ‘passive smoking’

Do you use electronic cigarettes? YES [ ] NO [ ]

We strongly advise all smokers to quit and are happy to help. See your welcome pack for details.

Please tick one box for each question

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Questions | 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 – 4 times per month | 2 – 3 times per week | 4+ times per week |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 – 2 | 3 – 4 | 5 – 6 | 7 – 8 | 10+ |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you found you were not able to stop drinking once you started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you needed an alcoholic drink in the morning to get you going?  | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Have you or someone else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |
| Has a relative/friend/doctor or health worker been concerned about your drinking or advised you to cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last 2 weeks how often have you been bothered by any of the following problems? Please tick the relevant boxes | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed or hopeless |  |  |  |  |
| Trouble falling or staying asleep or sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself or that you are a failure, or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. |  |  |  |  |
| Thoughts that you would be better off dead, or of hurting yourself in some way. |  |  |  |  |
| FOR SURGERY USE Total Score = /27 | 0 | 1 | 2 | 3 |

If you have not already done so, please collect a token from the receptionist and use the Health Monitor which will check your height, weight and blood pressure. Keep one slip for your own records and return the other to reception with your name and date of birth clearly written on it.

Checklist for completed forms:

* Pharmacy nomination: Completed [ ] Not applicable [ ]
* Summary Care Record Completed [ ] Not applicable [ ]
* Terms & Conditions Completed [ ] Not applicable [ ]

Thank you for completing this questionnaire. . If you would like to see the nurse to discuss your health, please do not hesitate to book an appointment.