Shelford Medical Practice
OVER 10 NEW PATIENT QUESTIONNAIRE

# PLEASE COMPLETE THIS FORM IN BLACK INK

If you have any difficulty in filling in this form, please speak to a Receptionist who will endeavour to help, or make an appointment for you with a nurse or health care assistant.
We may recommend you make an appointment with a member of clinical staff, after checking your information, in order to help you receive the best care whilst being registered with us.

| | |
|---|---|
| Name: | Date: |
| Address: | Date of birth: |
| | Marital Status: |
| | Occupation: |
| | Telephone Home: |
| | Telephone Mobile: |
| Postcode: | Telephone Work: |

Are you happy for us to send text messages about appointments and test results (to be introduced in the future)? Yes/No

| | | | |
|---|---|---|---|
| Next of kin | : Name: | Relationship: | Tel No: |

Names and Relationships of other people living in same home as you:

Do you have a carer? Yes/No

Name of Person: Telephone No:

Are you a carer? Yes/No
Please provide name contact number and reason e.g. partner/child/parent with learning difficulties or mental or physical illness.

Have you had a social services assessment?

Are you happy for us to leave messages with a named person about making appointments? Yes/No

Name of Person: Relationship:

Would you like a user name and password to register for our online services? Yes/No

Are you adopted? Yes/No

Would you prefer to collect your prescriptions from:

The Health Centre
Boots in Gt Shelford
Boots in Sawston

**Please note:** Boots ask for three clear working days from request to collection. If you are collecting from the health centre we endeavour to process all requests received before 9:30 by 5pm the same day.
We ask that you request your medication either online or in writing – we only accept telephone requests from patients that are housebound.

Please list any **illnesses or operations** that you have had, including dates, or anything you currently receive treatment for eg asthma, diabetes, lung problems, heart disease, stroke, atrial fibrillation, high blood pressure, epilepsy, depression, psychiatric illness, cancer, thyroid problems, kidney disease, liver disease, infectious disease.

*Continue overleaf as necessary*

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Please list any **medication** that you take regularly or attach a copy of a list from your last practice.
**NB:** if you are on medication, please make an appointment to see a doctor before your next medication is due.

*Continue overleaf as necessary*

Please list any **allergies** you have eg to any medications, and what happens

When did you last have a **tetanus** booster?

Do you have any **hearing or visual** problems? Yes/No
If yes please give details

Do you have any **mobility problems**? Yes/No Do you use a stick, frame etc? Yes/No
If yes please give details

Do you have any **learning difficulties**?
If yes please give details

**For women only**
When was your last cervical smear?
If you have had a hysterectomy, what was the date? Was the cervix removed as well as the uterus?

Are you using contraception?
If yes, please state what type. If a long acting method, such as injection, implant, intra uterine device (coil), when did you last have it checked or replaced?

Do you have any **family history of illness**? eg heart disease, strokes, cancers, genetic disorders, diabetes, thyroid disorders. *Continue overleaf if needed*

| Relationship | Condition | Age when diagnosed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Do you **smoke**? Yes/No
If yes how many a day?
(We encourage people to stop smoking and offer assistance – do make an appointment with one of our practice nurses)

| If you are an ex-smoker when did you give up? | Month | Year |
|---|---|---|

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| **Units of Alcohol** | |
|---|---|
| 1 unit | **Half pint** ordinary strength lager/beer/cider |
| | **25ml** measure of spirit |
| 1.5 units | **125ml** glass of wine |
| | **330ml** bottle of beer/cider/lager |
| 2 units | **330ml** bottle of alcopop |

| How many units of alcohol do you drink in an average week? | | | | | |
|---|---|---|---|---|---|
| None | 1-2 | 3-4 | 5-6 | 7-9 | 10 or more |
| How often did you have a drink containing alcohol in the last year? | | | | | |
| Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week | |
| How many drinks did you have on a typical day when you were drinking in the past year? | | | | | |
| None | 1-2 | 3-4 | 5-6 | 7-9 | 10 or more |
| How often did you have six or more drinks on one occasion in the past year? | | | | | |
| Never | Less than Monthly | Monthly | Weekly | Daily | Almost Daily |

If English is not your **first language**, which language does your household find it easiest to communicate in? Please state:
Do you have someone who can come to appointments to interpret? Yes/No
Please state their name and relationship to you:

**Please indicate your ethnic group.**

The government request that we collect this information in our database. These questions have been taken from the Commission for Racial Equality good practice guide for census purposes.

**What is your ethnic group?**

*Choose one section from A to E, and then tick the appropriate box to indicate your cultural background.*

A. White

- ☐ British
- ☐ Irish
- ☐ Any other White background, please state _____

B. Mixed

- ☐ White and black Caribbean
- ☐ White and black African
- ☐ White and Asian
- ☐ Any other Mixed background, please state _____

C. Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background, please state _____

D. Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other, please state _____

E. Chinese or other ethnic group

- ☐ Chinese
- ☐ Any other, please state _____

**Please state your religion,** _____
**or tick if you decline to do so**____I **decline** ☐

**If you are of school age, are you at school?** Yes/No