



## Castle Place Practice

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# New Patient Questionnaire

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## Contact Information

Name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Mobile Number	
Email Address	

Would you like to be added to the Text Message Appointment Reminder service?  
YES [  ] / NO [  ] If YES please ensure you include your mobile phone number above.

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## Summary Care Records

NHS Devon is planning to introduce a new system for managing your patient records, so that a brief summary of important information is available to healthcare professionals directly involved in treating you. The new NHS summary care records will be provided for every Devon resident who would like one.

### **What do I need to do to have an NHS summary care record?**

You don't need to do anything. Once registered with the practice a record will automatically be created.

### **Do I have to have an NHS summary care record?**

No. If you do not want us to create a record for you please speak to the receptionist and ask for a Summary Care Record Opt Out Form.

**If you would like more information on the Summary Care Record Program please speak to the receptionist.**

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**Ethnic Origin**

<b><u>White</u></b>		<b><u>Mixed</u></b>		<b><u>Asian or Asian British</u></b>		<b><u>Black or Black British</u></b>		<b><u>Chinese or Other Ethnic Group</u></b>	
British	[ ]	White & Black Caribbean	[ ]	Indian	[ ]	Caribbean	[ ]	Chinese	[ ]
Irish	[ ]	White & Black African	[ ]	Pakistani	[ ]	African	[ ]	Other	[ ]
		White & Asian	[ ]	Bangladeshi	[ ]				
Other:									

**First Language**

Please enter your main spoken language:

**Lifestyle**

Do you currently Smoke	Yes [ ]	No [ ]
If NO have you ever smoked?	Yes [ ]	No [ ]
If YES how many cigarettes do you smoke per day?		
If YES would you like Help / Information about quitting?	Yes [ ]	No [ ]
Do you have a drug or solvent abuse problem?	Yes [ ]	No [ ]
Do you eat a special diet, e.g. vegetarian or to lose weight?	Yes [ ]	No [ ]
If YES Please Specify		
How many days a week do you exercise?		
What form of exercise?		
What is your weight?		
What is your height?		
Do you have a living will?	Yes [ ]	No [ ]
<b><u>Women Only</u></b>		
Have you had a cervical (pap) smear test?	Yes [ ]	No [ ]
If Yes, When	Was it normal?	Yes [ ] No [ ]
Previous Pregnancies (Please include date, sex and weight)		

### Alcohol Screening Questionnaire

Questions	0	1	2	3	4	Your Score
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 had 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 / 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	

**Current Medical Status**

Please give the date of your last vaccinations: (Please tick if date unknown)			
Tetanus		Polio	
B.C.G		Measles	
Meningitis C		Rubella	
Travel Vaccinations please specify:			
Do you have a family history of:		If YES please specify family member	
Coronary Heart Disease under age 60	Y	N	
Stroke / TIA	Y	N	
Diabetes	Y	N	
Mental Illness	Y	N	
Respiratory Disease	Y	N	
Cancer	Y	N	
Other Diseases running in the family?	Y	N	Please specify below:
<b>Past Operations: Please include approximate dates.</b>			
<b>Previous Medical History.</b>			

**Previous Medical History**

Do you suffer from any of the following?						
Respiratory Disease	Y	N		Heart Disease	Y	N
Diabetes	Y	N		Migraine	Y	N
Asthma	Y	N		High Blood Pressure	Y	N
Epilepsy	Y	N		Depression	Y	N
Any other current medical problems?					Y	N
If YES please give details and dates.						
Are you currently on a hospital waiting list to see a specialist for surgery / treatment?					Y	N
If YES please give details and dates.						

Do you take any regular medication (Including any tablets, medicines, insulin, contraceptive pill, inhaler, etc)?	Y	N
If YES please specify.		
Are you allergic to antibiotics or any other Medication?	Y	N
If YES please give details.		
Any other known Allergies?	Y	N
If YES please give details.		

**Confidentiality**

Everyone working for the NHS has a legal duty to keep information about you confidential. As you may receive care from other organisations as well as the NHS (eg Social Services), we may need to share some information about you so that we can all work together for your benefit. We will only ever use or pass on information about you if others involved in your care have a genuine need for it.

Information will not be disclosed to third parties without your permission unless there are exceptional circumstances or the information is to be provided in an anonymised, encrypted or aggregated form (eg for research or statistical analysis).

Your information may be used by the practice for management, audit and research purposes.

Your information may be used by the NHS to assess the needs of the general population, review services, review care standards, for teaching purposes, to conduct health research and development, to audit NHS accounts and services, to pay your GP for the care they provide, to prepare statistics on NHS performance, to investigate complaints, legal claims or untoward incidents. Information for these purposes is generally supplied in an anonymised, encrypted or aggregated form.

You have the right to know what information we hold about you. If you would like to see your records, please refer to our Access to Medical Records policy available on our website or from reception

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Any other information you think may help us with your care.


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*Thank you for completing the questionnaire.  
Please bring it with you when you register.*