**Alastair Ross Medical Practice**

**This Practice is committed to supporting you to stay healthy. To do this, please take a few moments to complete the questionnaire below to enable us to update your records.**

**Title……….. Name……………………………………… DOB………………………**

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| **Contact details:**    Address ………………………………………………………………………………….  …………………………………………………………………………………………….  Telephone/Mobile number …………………………………………………………….  Do you consent to the practice leaving messages on your telephone answering machine if available? **YES**  **NO**  Do you consent to the practice sending text messages to receive notifications for clinical services? **YES**  **NO**  Email address: …………………………………………………………………………  Do you consent to the practice sending you emails regarding clinical services? **YES**  **NO** |

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| --- | --- | --- | --- | --- | --- |
| **Sexuality** | Heterosexual/straight | Gay/Lesbian | Bisexual | Other | Prefer not to say |
| **Gender Identity** | Female (including trans woman) | Male (including trans man) | Non Binary | In another Way |  |
| Is your gender identity the same gender you were assigned at birth? yes no | | | | | |

**Alcohol**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Questions – please score** | | | **Scoring system** | | | | | | | | | **Your score** |
| **0** | **1** | | | **2** | **3** | | **4** | |
| How often do you have a drink containing alcohol? | | | Never | Monthly  or less | | | 2 - 4 times per month | 2 - 3 times per week | | 4+ times per week | |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | | | 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 | |  |
| **Smoking status** | |  | Never | | |  | Ex-smoker | | |  | | Smoker – how many per day? | | |

Would you be interested in smoking cessation advice? Yes No

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| --- | --- | --- | --- | --- | --- | --- |
| **HIV Status** |  | Positive |  | Negative |  | Don’t Know |

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| --- | --- | --- |
| **Height** |  | **Weight** |

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| --- | --- | --- | --- | --- |
| **Are you a carer?**  Do you care for someone who is elderly, has a long-term illness or who has a disability? |  | **Yes** |  | **No** |

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| --- | --- | --- |
| **Have you ever served in the armed forces?**  **Is there a military veteran in your household?** | **Yes**  **Yes** | **No**  **No** |

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| Please list any medicines that you are currently taking, and the amount (or provide the repeat medication order slip from your previous surgery)  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  **You will need to book an appointment for a medication review in order to obtain your first prescription from the practice.** |

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| Please list any serious illnesses or operations and give dates (if known)  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………… |

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| Please list any vaccinations you may have had and give dates (if known)  ………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………… |

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| **Cervical History**  Do you have a cervix? Yes No  Have you had a hysterectomy? Yes Please give date ………………… No  When was your last cervical smear : Please give date……..………………………………………………… |

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| **Ethnicity – please circle** | | | White British | | | Irish | | Gypsy | Other white background |
| African | Caribbean | Any other Black/African/ Caribbean Background | | White/Black Caribbean | | White/Black  African | | White / Asian | Mixed/multiple Ethnicity |
| Chinese | Indian | Pakistani | | Bangladeshi | | Other Asian | | Arab | Any other ethnic group |
| **Language spoken** |  | | | | **Interpreter** | | **Yes / No** | | |

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| **Communication Needs**  Do you have any special communication requirements? Yes No  If so, what are these requirements? ………………………………………………...……………………  **Do you need British Sign Language interpretation? Yes No**    **Do you need a format other than standard print?** **Yes No**  Please explain your requirements …………………………………………………..  **Can you explain what other support would be helpful to you?** ………………………………………………………………….  **What is the best way for us to send you information?** |

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| **Do you consider yourself to have a disability**  Physical  Sensory  Learning Disability/Difficulty  Mental Health  Other (please state) |  | **Yes**  **Yes**  **Yes**  **Yes** |  |  | **No**  **No**  **No**  **No** |