**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 | Monthlyor 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** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 NoHave you had a hysterectomy? Yes Please give date ………………… NoWhen 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/BlackAfrican | 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 NoIf 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?**  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you consider yourself to have a disability**Physical SensoryLearning Disability/DifficultyMental HealthOther (please state) |  |  **Yes** **Yes** **Yes** **Yes** |  |  |  **No** **No** **No** **No** |