

ETHNIC INFORMATION

We have been asked to record ethnic group data on patients so that the NHS will be in a better position to address health inequalities, difficulties in access and discrimination experienced by some black and minority ethnic individuals and communities. This is seen as a pre-requisite to the identification and design of services appropriate to local need.

| Census Group | Read Code | Please Tick |
|---|-----------|-------------|
| White British | 9i0.. | |
| White Irish | 9i1.. | |
| Any other White background | 9i2.. | |
| | | |
| Mixed White & Black Caribbean | 9i3.. | |
| Mixed White & Black African | 9i4.. | |
| Mixed White & Asian | 9i5.. | |
| Any other Mixed Background | 9i6.. | |
| | | |
| Indian (Asian or Asian British) | 9i7.. | |
| Pakistani (Asian or Asian British) | 9i8.. | |
| Bangladeshi (Asian or Asian British) | 9i9.. | |
| Any other Asian Background (Asian or Asian British) | 9iA.. | |
| | | |
| Caribbean (Black or Black British) | 9iB.. | |
| African (Black or Black British) | 9iC.. | |
| Any other Black Background (Black or Black British) | 9iD.. | |
| | | |
| Chinese | 9iE.. | |
| Any other Ethnic Group | 9iF.. | |
| | | |
| I refuse to give my Ethnic Group | 9iG.. | |

MAIN SPOKEN LANGUAGE

Please indicate your main spoken language

Many thanks for taking the time to complete this form

Twickenham Park Surgery
 17 Rosslyn Road, East Twickenham, Middlesex TW1 2AR
 Tel: 020 8892 1991 Fax : 020 8744 0533

TWICKENHAM PARK SURGERY

NEW PATIENT QUESTIONNAIRE

PERSONAL DETAILS

Surname Forenames

Address

.....

Date of Birth Home Tel

E-mail address:..... Mobile Tel

Would you like access to book appointments online? YES / NO

NEXT OF KIN

Name

Relationship and Contact Number.....

SOCIAL

Please tick as appropriate:

- Married Civil Partner Divorced Single Widowed
- Sharing Living Alone Living with Partner

Present Occupation

What regular exercise do you take

Do you have a special diet

Please supply the following details regarding smoking

Never smoked Number of cigarettes/day

Smoker Number of packs/day.....

Ex-smoker Number of cigars/week.....

Date stopped Pipe smokers –

Years smoking Number of ounces per week

If you are over 16, please complete the following details regarding alcohol

How many units of alcohol do you drink per week (taken that one unit is equal to half a pint of beer, one standard glass of wine or one standard measure of spirits)

How often do you have a drink containing alcohol

- never
- monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

How often do you have 6 or more drinks on 1 occasion

- never
- less than monthly
- monthly
- weekly
- daily or almost daily

MEDICAL

Weight / Height...../.....

Do you have any allergies (please specify)

What was the date of your last tetanus vaccination

Are you on any regular medication (please specify)

PAST ILLNESSES/OPERATIONS

| Date | Left or Right If appropriate | Illness/Operation |
|------|---------------------------------|-------------------|
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| | | |

WOMEN ONLY

What is your method of contraception (if used)

When and where did you last have a smear

Was it normal

Have you ever had a mammogram and if so, when

Was it normal

Please give details of any pregnancies:

| Date | Outcome |
|------|---------|
| | |
| | |
| | |
| | |

FAMILY HISTORY

Please indicate if your parents, grandparents, brothers or sisters have had any of the following and their age at onset:

| Condition | Relationship to Patient | Age at Onset |
|----------------------|-------------------------|--------------|
| Heart attack | | |
| Stroke | | |
| High blood pressure | | |
| Diabetes | | |
| Asthma | | |
| Cancer of the bowel | | |
| Cancer of the ovary | | |
| Cancer of the breast | | |
| Glaucoma | | |
| Epilepsy | | |

Are there any other hereditary problems or important family illnesses:

| Condition | Relationship to Patient | Age at Onset |
|-----------|-------------------------|--------------|
| | | |
| | | |
| | | |
| | | |

CARERS

A carer is anyone who gives unpaid care to a relative or friend who may be disabled, elderly, frail, or ill and who cannot manage without this help. People often do not recognise themselves as carers. They can be any age – children or adults. They may provide full-time or part-time care or share the care with another person. We like to identify those who are caring for another person so we may offer them appropriate support.

Are you a carer

If yes, please give the name of the person for whom you care and their date of birth or address

.....

Do you have a carer

If yes, please give the name of the person who cares for you and their date of birth or address

.....

| |
|---|
| <p>Would you like your prescriptions to go electronically to a chemist? If so which one?</p> <p>.....</p> |
|---|

| |
|---|
| <p>Opt In / Opt Out: Would you like your Medication and Allergy records to be available to other NHS agencies?</p> <p style="text-align: center;">YES / NO</p> <p style="text-align: center;">Ask at reception if you would like more information about this.</p> |
|---|