

# HOLBROOK AND SHOTLEY SURGERY - NEW PATIENT QUESTIONNAIRE

Name ..... Date of Birth ...../...../.....

Home Tel ..... Mobile .....

Email .....

Religion ..... Ethnicity .....

First Language ..... English Speaking **YES/NO**

**NEXT OF KIN DETAILS**

Name ..... Relationship ..... Tel .....

Address .....

**Do you have any allergies / special needs/ disabilities?**

If yes please specify.....

**REPEAT MEDICATION REQUIRED YES/NO** Details .....

Please note that if you are on any repeat medication, you will need to see a GP with your previous medication list, before you need your next prescription. Please indicate by ticking a box below which surgery you would prefer to collect your prescription from.

Holbrook     Shotley

**FAMILY HISTORY** (immediate family only)

Any important family illnesses or diagnoses  
.....

**ALCOHOL STATUS**

QUESTIONS	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**

Smoker **YES/NO** How many per day? .... Ex-Smoker **YES/NO**

If you are a smoker would you like smoking cessation advice **YES/NO**

**CARERS**

Do you have a carer? **YES/NO** If yes please provide details .....

Are you a carer? **YES/NO** If yes please provide details .....

**SPECIFIC NEEDS**

Have you nominated someone to speak on your behalf? eg: Power of Attorney **YES/NO**

If yes please provide details and copy of POA/Letter of Authority .....

**PATIENT PARTICIPATION GROUP**

The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views and ideas for making services better. Are you interested in getting involved **YES/NO**

**CONSENT TO CONTACT**

I consent to appointment confirmations / reminders / test results etc being sent to me

**SMS TEXT MESSAGING**

**EMAILS**

Consent Given  Consent Refused  Consent Given  Consent Refused

I confirm that I will update my details if they change.

**PLEASE PROVIDE TWO SEPARATE FORMS OF IDENTIFICATION ONE FOR ADDRESS CONFIRMATION AND ONE PHOTO ID.**

...../...../.....  
**Your name (capitals)      Your signature      Date**

**For office use only** Form accepted by ..... (initials)

Named GP .....  Informed patient of registered GP

**Confirmation seen (this must be official and not confirmation of an online purchase for example)**

Driving licence,  Utility bill,  Bank statement,  Other.....