GRAHAM ROAD SURGERY

New Patient Questionnaire

Mr ☐ **Mrs** ☐ **Ms** ☐ **Other** _____ **D.O.B** _____

First Name _____ **Surname** _____

Home Phone _____ **Work Phone** _____

Mobile Phone _____ **Email address** _____

Ethnicity:

White	**Black or Black British**	**Asian or Asian British**
British ☐	African ☐	Bangladeshi ☐
Irish ☐	Caribbean ☐	Indian ☐
Any other white background	Any other black background	Pakistani ☐
_____	_____	Other _____
Mixed Background	**Chinese or Other Ethnic Group**	**If you do not wish to state your ethnicity please tick here** ☐
White & Asian ☐	Chinese ☐	
White & Black African ☐	Any other ethnic group	
White & Black Caribbean ☐	_____	
Any other mixed background	_____	
_____		

We would like to send you text reminders of appointments. Please tick one of the following boxes to say opted in or opt out.

Stay opted in ☐ **Opt out** ☐

Health Status

Height _____ CM **Weight** _____ KG **Blood Pressure** _____

Please tick one of the following boxes to collect your prescriptions from.

Asda		Day Lewis		Locking Pharmacy	
Boot High Street		Jays		Milton Pharmacy	
Boots Locking Castle		Lloyds Sainsbury's		Morrison's	
Boots Bourneville		Lloyds White Cross		Tudor Lodge	
Boots Oldmixon		Lloyds High Street		Tesco	
Well (Coop)		Lloyds One Stop		Rowlands	

If you are on regular, repeat medication please ensure you attach your prescription order sheet to this form.

Please make sure you have written the units the measurements were taken!

Average alcohol consumption per day _____ **(1 unit = 1 small glass of wine/ 1 measure of spirits/ 1/2 pint beer/larger)**

Exercise:

0 times/week ☐ **1 time/week** ☐

2 times/week ☐ **3+ times/week** ☐

Family History (Blood Relative):

	Paternal	Maternal	Sibling		Paternal	Maternal	Sibling
Heart Disease (> 60 years)	☐	☐	☐	Heart Disease (< 60 years)	☐	☐	☐
CVA / Stroke	☐	☐	☐	Diabetes	☐	☐	☐
Asthma	☐	☐	☐	Gastrointestinal	☐	☐	☐

Smoking Status:

Never ☐ **Ex-smoker** ☐ **Cigarettes** ☐

Rolls Own ☐ **Pipe** ☐ **Cigars** ☐

If you're an Ex-smoker, please provide the following details: **Date stopped** _____

How much did you use to smoke?

1/day ☐ **1-9/day** ☐ **10-19/day** ☐

20-39/day ☐ **40+/day** ☐ **Unsure of amount/day** ☐

Ex-cigar ☐ **Ex-pipe** ☐ **Rolled own, how many grams used weekly** _____

Past/Current Medical History (please include date diagnosed)

Myocardial Infarction ☐ _____ **Hypertension** ☐ _____

Angina ☐ _____ **Diabetes** ☐ _____

Stroke/CVA ☐ _____ **Heart Failure** ☐ _____

Other _____

_____

Next of Kin Name and Contact Number: _____

_____

Do you wish to opt out of sharing your medical records?

If you do not express a preference then your information will be shared. The Law presumes that if you don't express a preference that you accept sharing

Summary Care Records	**Yes** ☐	**No** ☐
Connecting Care	**Yes** ☐	**No** ☐
Care Date / HSCIC	**Yes** ☐	**No** ☐