**Fowey River Practice**

Reg Accepted & chkd by: ………………….

Added to comp by: …………………………..

Appoint Made: ……………………….………..

Appoint with: …………………………………..

Height/Weight entered: ……….…………

Smoking/Alc entered: ………………………

Staff Name: ……….……………….……………

SCR Consent: ……………………………………

SMS Opt out: (inform PEJ)…………………

NPQ scanned on: ………………….…..……..

**New Patient Questionnaire**

WE ARE A RESEARCH ACTIVE PRACTICE

**Your Contact Details:**

Title Surname:

Date of Birth: First Names:

Occupation: Previous Surnames:

Home Address: Home Telephone:

Work Telephone:

Postcode: Mobile Telephone:

Email address:

If you would like to use our on-line facilities please complete an online consent form and return it in person with valid photo ID or your passport

Proof of identity and address provided:

🞎 Birth Certificate 🞎 Driving Licence 🞎 Passport 🞎 Utility Bill

🞎 Allowance Book 🞎 Solicitor’s Letter 🞎 Offer of Tenancy 🞎 Other (please specify)

We use SMS/email to contact our Patients, please tick if you **DO NOT** want to received these 🞎

***Providers of health and adult social care services have a duty to support those who access their services who have sensory impairments and/or learning disabilities. Please complete the following section if you***

***fall into this category.***

In accordance with The Accessible Information Standard (SCCI 1605 (Accessible Information)please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual):……………………………………………………………………….............

To help me communicate I use (e.g. a talking mat, hearing aids):………………………………….……….……………….…

I need information in (e.g. braille, easy read):……………………………………………………………………………………….…..

If you need to contact me the best way is (e.g. email, telephone:……………………………………………………………..

What is your first language?

Do you need an interpreter? Yes 🞎 No 🞎

**Information about you:**

|  |
| --- |
| Height \_\_\_\_feet \_\_\_\_Inches |
| Weight \_\_\_\_Stone \_\_\_\_Pounds |
| Waist Measurement \_\_\_\_Inches |

|  |
| --- |
| (Women only) Have you had a cervical smear?  🞎yes 🞎no  *(please state where,when & result if possible)* |

**Next of Kin/Emergency Contact**

|  |
| --- |
| Name/Relationship to you/Telephone no./Address (if different to yours) |

|  |  |
| --- | --- |
| Name/Relationship to you/Telephone no./Address (if different to yours) |  |

**Carers Information**

A carer is a friend/family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

|  |
| --- |
| **Are you looked after by someone whose support you could not manage without?**  If yes, what is their name and contact number?  Do you consent for your carer to be informed about your medical care? Yes 🞎 No 🞎 |

|  |
| --- |
| **Do you look after someone where without your support they could not manage?**  If yes, are they one of our patients? No 🞎 Yes 🞎 (If yes, please state who)  What is your relation to the person you care for?  Do you need some support with caring for this individual? Yes 🞎 No 🞎 |

**Have you ever had any of the following conditions?**

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Diabetes (type1 or type 2) | year | 🞎 Heart Disease | Year |
| 🞎 High Blood Pressure | year | 🞎 Rheumatoid Arthritis | Year |
| 🞎 Osteoporosis/Bone fractures | year | 🞎 Stroke | Year |
| 🞎 Peripheral Vascular Disease | year | 🞎 COPD | Year |
| 🞎 Emphysema | year | 🞎 Asthma  **If yes, date of last inhaler:** | Year |
| 🞎 Cancer | year | 🞎 Learning Disability | Year |
| 🞎 Epilepsy | year | 🞎 Mental Illness (inc depression) | Year |

**Do you have Family History of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Diabetes (type1 or type 2) | who | 🞎 Ischaemic Heart Disease | who |
| 🞎 High Blood Pressure | who | 🞎 Raised Cholesterol | who |
| 🞎 Osteoporosis | who | 🞎 Stroke/CVA | who |
| 🞎 DVT /Pulmonary Embolism | who | 🞎 COPD | who |
| 🞎 Any Cancer type? | who | 🞎 Asthma | who |
| 🞎 Breast Cancer | who | 🞎 Thyroid Disorder | who |

|  |
| --- |
| **Any further relevant medical history:** |

|  |  |
| --- | --- |
| **List of your current medication – and date of last issue** | |
| **FEMALES ONLY**  **Are you currently on Contraception?** 🞎yes 🞎no | **PLEASE STATE TYPE**  **IF PILL DATE OF LAST PILL CHECK**  **IMLANON/COIL DATE OF INSERTION** |

**Smoking:**

|  |
| --- |
| 🞎 Never smoked |
| 🞎 Current smoker – number of cigarettes/cigars per day: |
| 🞎 I would like advice on giving up |
| 🞎 No I do not wish to give up |
| 🞎 Ex-smoker – number of cigarettes/cigars per day: Date stopped: |
| If you would like to give up smoking, please book an appointment with our Stop Smoking Adviser, Leanne Smith |

**Alcohol:**

|  |
| --- |
| How often do you have a drink that contains alcohol?  🞎 Never 🞎 Monthly or Less 🞎 2-4 times per week 🞎 4+ times per week |
| How many standard alcoholic drinks do you have on a typical day when you’re drinking?  🞎 1-2 🞎 3-4 🞎5-6 🞎7-8 🞎10+ |
| How often do you have 6 or more standard drinks on one occasion?  🞎 Never 🞎Monthly or Less 🞎2-4 times per month 🞎 4+ times per month |
| How many Units of alcohol do you consume in a week? (Use the unit guide below) \_\_\_\_\_\_\_\_ units per week |

**Unit Guide:**

|  |  |
| --- | --- |
| Single small shot of Spirit (25ml) | 1 Unit |
| Alcopop | 1.5 Units |
| Small glass of Wine | 1.5 Units |
| Bottle of Lager/Beer/Cider (330ml) | 1.7 Units |
| Can of Lager/Beer/Cider (440ml) | 2 Units |
| Pint of low strength (3.6%) Lager/Beer/Cider | 2 Units |
| Standard glass of Wine | 2.1 Units |
| Pint of higher strength (5.2%) Lager/Beer/Cider | 3 Units |
| Large glass of Wine | 3 Units |
| Bottle of Wine | 10 Units |