Dr LM Taylor & Partners

13- 15 years New Patient Questionnaire

Today's Date

Please complete this confidential questionnaire. Information provided on this form will be added to your clinical records unless you let the receptionist know otherwise.
Please complete in BLOCK CAPITALS and tick the boxes as appropriate.
This information is important in helping your doctor provide medical care.

Does the chemist order / deliver your prescriptions Yes / No (please circle)
If you answered 'YES' what is the name and address of the chemist:

Full Name:	**Mobile Number:** **Home Telephone Number:** **Email address:**
Mr / Mrs / Miss / Ms / Other……..	
Address and Postcode	**Previous GP**
Previous address: **If from abroad date first entered UK**	**Next of Kin Name and relationship:** **Next of Kin contact Number:** **Next of Kin address:**

Date of Birth	**Previous / Mother's surname if different:**		**NHS no.**		
Can we text you?	**Yes / No**	**Town & Country of Birth**	**Gender:**	**Male:**	**Female:**

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other – please state**	
Your main or 1st language Spoken / Understood:	**Please state:**	**Do you need a translat0r/interpreter?**	**Yes / No**

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**	**Date Stopped smoking:**
If so, how many cigarettes / cigars / tobacco do you smoke in a day?			**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*			

Its NEVER too late to stop smoking you will ALWAYS benefit! If you want help to stop smoking call ***0800 169 4219***

How often do you exercise?	**No. times per week**	**Type(s) of exercise:**	

If you would like help and support with stopping smoking, losing weight or reducing your alcohol intake please ask the receptionist or health care assistant/nurse.

Your Medical History:

Are there any medications you have been advised NOT to take?	
Why can't you take this medication?	
What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	
Please list brothers/sisters and all adults with a caring role e.g parents/guardians /carers	**Name** **Relationship**
Have you ever been a drug abuser?	

Are there any serious family diseases that affect your parents, brothers or sisters. (tick all that apply)				
Diabetes	**Heart attack**	**Heart attack under age 60**	**Bowel Cancer**	**Glaucoma**
Breast cancer		**High blood pressure**	**Asthma**	**Stroke**
Thyroid disorder		**Any other important family illness?**		

If you provide help or support to a family member, friend or child who because of physical, mental illness, substance misuse, disability or old age, could not manage without you – YOU are a CARER.

If you are a carer, please state name address phone number of the person you care for:	**Emergency name/contact number for cared for person:**	**Referral to Willows project (5-17 yrs) offered Yes/ No**
If you have a Carer, please state their name/address/phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer contact details: (please get consent from your carer to provide their details)** **Signed…………………………………Date……………………**	**Carer consent given** **YES / NO**

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Guide Dog/Assistance Dog' User?	
Please state any Physical or Mental disabilities you have:	
Please state any communication needs e.g. require large print, speak loudly, text message, email, telephone, verbal information, language line.	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	

Females only:	
Method of contraception (if used):	

Sharing Medical Information.

The NHS are changing the way your health information is stored and managed. The practice now keeps computerised medical records for all its patients. We will share this information with other health providers you may be seeing e.g. district nurses, health visitors, physiotherapists etc. If you do not wish us to share your information please inform the receptionist.

Virtual Patient Opinion Forum

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. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. If you are interested in finding out more about our Virtual Patient Opinion Forum please tick the box below.

Yes, I am interested in becoming involved in the Virtual Patient Opinion Forum.	Yes

Patient Signature:		Signature on behalf of Patient:	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

Thank you for completing this form

For more information about the services we offer, please refer to our practice leaflet or see our website: shaftesbury-churchview.co.uk