

**Partners:**

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Dr Zara Aziz  
Dr Neil Robertson

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## OLD SCHOOL SURGERY NEW PATIENT QUESTIONNAIRE

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### YOUR DETAILS

Name of Patient .....

Date of Birth ..... Marital Status .....

Address .....

.....

..... Postcode .....

Landline ..... Mobile .....

Email Address .....

Have you ever been registered with this Practice before? **YES / NO**

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### YOUR LIFESTYLE

What is your height? .....

What is your weight? .....

Smoking status: Never smoked .....

Current smoker ..... If so, how many a day? .....

Ex-Smoker ..... Date Stopped .....

Alcohol Status	0	1	2	3	4
How often do you have a drink that contains alcohol	Never <input type="checkbox"/>	Monthly or less <input type="checkbox"/>	2-4 times a month <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4+ times a week <input type="checkbox"/>
How many units of alcohol Do you drink on a typical Day when drinking? 1 unit = 1 glass of Wine (125ml), 1 single measure of spirits or half a pint of lager	1-2 <input type="checkbox"/>	3-4 <input type="checkbox"/>	5-6 <input type="checkbox"/>	7-8 <input type="checkbox"/>	10+ <input type="checkbox"/>
How often do you have 6 or more units on one occasion? Or 8 units or more if you are male?	Never	Less than Monthly	Monthly	Weekly	Daily/Almost Daily

If you score over 5 please ask the Receptionist for an additional form, which you will need to complete.

### ETHNIC ORIGIN:

- White British
- Irish
- Any other white background
- Black British / African / Caribbean
- Any other Black background
- Mixed /Multiple Ethnic Background
- Asian / Asian British
- Other (please specify)

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## DISABILITY ACCESS

If you have any special needs please let us know, so that we can help you and ensure you get the right support in the future.

Your Disability .....

Your Requests .....

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## OTHER

Are you a Carer?

Yes ☐ No ☐

Emergency Contact:

Name: Mr/Mrs/Ms .....

Relationship to patient .....

Are you registered at the surgery Yes ☐ No ☐

Telephone No .....

Next of Kin:

Yes ☐ No ☐

Can discuss Record  
with them

Yes ☐ No ☐