Your Drinking/Alcohol Consumption

(*Average* UK units below)

Pint of Regular Beer/Lager/Cider | Alcopop or Can of Lager | Glass of Wine (175ml) | Single Measure of Spirits | Bottle of Wine

I would prefer not to disclose my alcohol consumption ☐

How much alcohol do you drink per week? …… (in units, *see above*)

Please answer the questions below: write your scores in the boxes at the side
A total score of 3 or more indicates hazardous or harmful drinking.

Score →	0	1	2	3	4	
How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only complete the following questions if you answered monthly (scored 2) or less above						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative / friend / Doctor / health worker been concerned about your drinking and advised you to cut down?	Never		Yes but not in the last year		Yes during the last year	

Carers

Are you are Carer? Yes ☐ No ☐

Who Do You Care For: ……

Their Address: ……

…… Post Code: ……

Phone Number: ……

Do you have a Carer? Yes ☐ No ☐

Who Cares For You: ……

Their Address: ……

…… Post Code: ……

Phone Number: ……

Your Emergency Contact

Mr/Mrs/Miss/Ms/Other➔( )

First/Given Name: ……

Their Address: ……

……

Home Phone: ……

Relationship To You: ……

Last/Family Name: ……

Post Code: ……

Mobile Phone: ……

The Coastal Partnership

New Patient Questionnaire

RCGP ACCREDITED PRACTICE 2014 — 2017

The information that you provide on this form will be handled in the **strictest confidence** by both your clinician and the Practice to get to know you and your medical history. If you are concerned about any of the questions, please leave them blank; your clinician will be able to clarify any points. It would be appreciated if you would return the completed form to the surgery as soon as possible or bring it with you when you first visit the Nurse or Doctor.

> PLEASE USE BLACK INK TO COMPLETE THIS FORM <

About You

Mr/Mrs/Miss/Ms/Other➔( ) Date of Birth: ……/……/……

First/Given Name: …… Last/Family Name: ……

Marital Status: Married ☐ Single ☐ Widowed ☐ Re-married ☐
Divorced ☐ Separated ☐ Co-Habiting ☐ Civil P'ship ☐

Your Home Address: ……

…… Post Code: ……

Home Phone: …… Mobile Phone*: ……

Ethnic Origin: …… First Language: ……

Occupation: ……

Previous Doctor's Details Name: ……

Practice Address: ……

…… Post Code: ……

Have you ever been registered with this Partnership before? Yes ☐

Would you like online access to manage your healthcare? Yes ☐
You can book appointments, request repeat medication, access your coded medical record, etc.

Preferred pharmacy for electronic prescriptions (EPS): ……
Please ask for or download the leaflet for further information about EPS.

Appliances: ……

Your Current Medication

Please attach a separate sheet, if required, of your current medication, which includes: name of drug/medicine; strength (e.g. 10mg, 20mg, etc.) and dosage (i.e. times per day).

If you are on any regular medication, please make an appointment for a check.
Please bring along any repeat medication slips that you may have from your previous Doctor.

By providing your mobile number, you **consent to receiving text message reminders for appointments and/or Practice medical campaigns (e.g. Flu vaccine). Please let your surgery know if you would prefer not to receive these messages. **Your mobile number will not be used** for any other messaging purpose or passed onto any other organisations. **We securely share your information with other services treating you;** please see "**Practice Standards> Confidentiality…**" on our website for further information. If you do not have access to the internet, please ask at reception.*

Please turn to page 2 ➔

Do you have any of the following medical problems?

Tick all those appropriate, and please provide the **year** (if known).

	Year		Year
☐ High Blood Pressure	( )	☐ Angina/Heart Attack	( )
☐ Over/under active thyroid	( )	☐ Gastritis/Peptic ulcer	( )
☐ Arthritis/Gout	( )	☐ Asthma	( )
☐ Diabetes (insulin dependent Y/N)	( )	☐ Mental Illness/Depression	( )
☐ Lung Disease/Bronchitis	( )	☐ Epilepsy	( )
☐ Cancer *(please specify)*	……..……		( )
☐ Other Problems *(please specify)*	……..……		( )
	……..……		( )

Your Allergies

Are you allergic or sensitive to any medication, food, animals, etc.?

Your Immunisations

Have you been immunised against any of the following? If so, please give dates.

Tetanus Yes ☐ No ☐ ➔ if **Yes** ➔ Date: ……/……..…./……

Influenza (Flu) Yes ☐ No ☐ ➔ if **Yes** ➔ Date: ……/……..…./……

Pneumococcal Yes ☐ No ☐ ➔ if **Yes** ➔ Date: ……/……..…./……

Your Smoking – *We strongly advise that you do NOT smoke*

I would prefer not to disclose my smoking status ☐

Have you ever smoked? Yes ☐ No ☐
➔ if **Yes**, do you smoke now? Yes ☐ No ☐ ➔ if **No**, when did you stop? ...../...../.....

➔ …**or** if **Yes**, do you smoke cigarettes/cigars/pipe/roll your own, and how much?

Cigarettes …… (per day)

Cigars …… (per day)

Pipe / Roll Your Own …… (ounces / grams per week)

If you currently smoke and would like help giving up, would you like us to help you? Yes ☐ No ☐

Your Memory

Are you worried about your memory? Yes ☐ No ☐ ➔ if **Yes**, please give details here

Accessible Information Standard

Do you require help with information? Yes ☐ No ☐ ➔ if **Yes**, please give details here
(e.g. different formats, Braille, email, large print, sign language, etc.)

Your Family History

Do you, or any of your family or close relations, have any of the following conditions? Tick all those appropriate, and please write beside the family member affected.
Please include any brother(s) or sister(s) and any serious illnesses they may have suffered.

Sugar Diabetes	☐	➔	*Who:* ……..…..…..….
High Blood Pressure	☐	➔	*Who:* ……..…..……
Heart Attack	☐	➔	*Who:* ……..……
Asthma	☐	➔	*Who:* ……..……
Anxiety Disorders	☐	➔	*Who:* ……..……
Nervous System Disorders	☐	➔	*Who:* ……..……
Congenital Diseases	☐	➔	*Who:* ……..……
Epilepsy / Fits	☐	➔	*Who:* ……..……
Cancer	☐	➔	*Who:* ……..……
Other Diseases *(please specify)*			
……..….	☐	➔	*Who:* ……..……
…….	☐	➔	*Who:* ……..……
…….	☐	➔	*Who:* ……..……

No Relevant Family History ☐

Are your parents still alive and in good health?

Mother: ……..…… Father: ……..…….……

(if either have died, please could you say how old they were when they died and what the known cause of death was, in the box below)

If you have any specific health issues that you would like to discuss, please give details below and you will be contacted by one of our Nurses.

Women Only

Have you had a cervical (cancer) smear: Yes ☐ No ☐

➔ If **Yes**, what date was your last smear: ……/……/……

Where did you have the smear taken: Doctor / Clinic / Private / Hospital *(**circle** as appropriate)*

Have you had a hysterectomy? Yes ☐ No ☐ ➔ if **Yes**, what year: ……..