Park Parade Surgery
New Patient Questionnaire

As a new patient with this practice, it would be helpful if you could provide the following information. This will help us to assess how the practice can best serve your healthcare requirements.

YOUR DETAILS

Name…… Date of birth……

Your occupation……
……

Telephone No: …….. Mobile No: …….

e.mail address……..... Door code if any ……

please confirm if okay for surgery to contact via text/email Yes/No

Next of kin …….. . Relationship …….

Address
……
……..

Telephone no: ……. Mobile no: …….....

Are you a carer for another person? Yes/No

If yes name of person
……

Do you yourself have a carer? Yes/No

If yes carer details: name:…….Contact No: ……

If you are a carer please ask at reception for a form to complete with your details.

Have you ever served in the armed forces? Yes/No

ETHNICITY: Please tick which best describes your ethnic background

British …….
Irish …….
Other white background ……..
White and Black Caribbean …….
White and Black Africa ……..
White and Asian ……
Other mixed background …….
Indian or British Indian …….
Pakistani or British Pakistani ……..
Bangladeshi or British Bangladeshi …….
Other Asian background ……
Caribbean …….
African ……
Other Black background ……
Chinese ……
Other ……
Do not wish ethnicity to be recorded …….

LANGUAGE: What is your first language?

English …….
Other – Please state …….
Do not wish first language to be recorded ……..

SMOKING STATUS: Please tick

Never smoked ……

Ex-smoker ……

Current smoker ……..…
.
If you are a current smoker, would you like advice on how to stop? **YES/NO**

ALCOHOL (16 years and over only) Audit C

Please circle the answer that is correct for you

How often do you have a drink containing alcohol?

Never (0) Monthly or Less (1) 2 – 4 times a month (2) 2-3 times per week (3) 4 or more times a week (4)

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 – 9 (3) 10 or more (4)

How often do you have six or more drinks on one occasion?

Never (0) Less than Monthly (1) Monthly (2) 2 – 3 times per week (3) Four or more times per week (4)

Total Score (please add together your 3 scores above)…….

CHILDREN:

If you have children living with you, please give their names and dates of birth. (Parents of children under school age or a child with a particular special need will be contacted by a Health Visitor)

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……

……
……

……
……

OTHER INFORMATION ABOUT YOURSELF:

Height……Weight……..

When did you last have your blood pressure checked?.....

When did you last have a Tetanus Vaccination?.....Polio Vaccination…….

IF FEMALE: When did you last have a cervical smear?.....

ALLERGIES:

Do you have any allergies to drugs? YES/NO

If Yes, please give details:

Drug…….Reaction (ie rash, vomiting, diarrhoea etc)……

Drug……Reaction……
……

Communication and/or information needs – Please tell us if you need information in a format that you can understand and any support you may need to communicate.

For example:
Do you use British Sign Language (BSL) and require an interpreter?
Are you a lipreader or hearing aid user?
Do you require letters in large print or an easy read format?

Please indicate your needs below:

……
……
……

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE