Leckhampton Surgery
New Patient Questionnaire

Welcome to Leckhampton surgery.
Your notes will be requested but in the meantime to help us provide you with the best possible care please provide us with the following information:

About you:

Full name			
Address			
	Postcode:		
Telephone	Home:		
	Mobile:		
	Work:		
Are you happy to receive text messages?		Yes	No
Email address			
Date of birth			
Occupation			
Household members	Name	Relationship(eg. partner, child)	
Are you a carer for a friend or relative?		Yes	No
Are you cared for by a friend or relative?		Yes	No
Name of carer			
Carer contact details			
Special access requirement eg. vision/hearing/mobility/translator			

Height	
Weight	
Waist measurement	

About your ethnic origin:

British/Mixed British		White and Black Caribbean	
Irish		Other Mixed background	
Chinese		Indian or British Indian	
Other white		Welsh	
Caribbean		Scottish	

About your lifestyle:

Smoking Status: Please tick		I have Never Smoked Tobacco	
Trivial smoker (over 1cig/day)		Ex-moderate smoker (10-19 cigs/day)	
Ex-trivial smoker (over 1cig/day)		Heavy smoker (20-39 cigs/day)	
Light smoker (1-9 cigs/day)		Ex-heavy smoker (20-39 cigs/day)	
Ex-light smoker (1-9 cigs/day)		Very heavy smoker (over 40 cigs/day)	
Moderate smoker (10-19 cigs/day)		Ex-very heavy smoker (over 40 cigs/day)	
Date you gave up smoking?			
Are you interested in giving up smoking?			

Your Alcohol History

Please circle:

How often do you have a drink that contains alcohol	Never	Monthly or less	2-4 times/month	2-3 times/week	4+times/week
How many standard alcoholic units do you have in a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily

About your medication history:

Regular medication. Please attach list or write here:		
Name of drug	Dose	Frequency

Do you have any allergies?	Yes	No
Please list with details of type of reaction:		
Are you allergic to Penicillin?	Yes	No
Any adverse drug reaction?	Yes	No
Nominated Pharmacy:		

Immunisation History

Please attach any immunisation information that you have

Date of last flu injection	

About your medical history:

Please tick if you have any of the following long term conditions:	
Asthma	
High blood pressure	
Diabetes Type I	
Diabetes Type II	
Stroke	
Heart attack	
Kidney disease	
Chronic lung disease	
Epilepsy	
Thyroid problems	
Long term mental health condition	
Rheumatoid arthritis	

Please list any other on-going medical problems:

Women only:		
Contraception used:		
Hysterectomy?	Yes	No
Are you pregnant?	Yes	No
	Due date:	

Thank you for taking the time to complete this form as accurately as possible.
Your registered doctor will review this paperwork and decide if you need review. You will be contacted by the surgery to arrange this if needed.
If you would like to discuss your future medical care with your registered doctor a telephone call can sometimes be a good place to start.
Our nurses offer a smoking cessation clinic to all who are interested. Please contact reception on **01242-539080** to arrange any appointments.

Dr to complete:

Single doctor appointment		**Tel call nurse**	
Double doctor appointment		**Pharmacy meds review**	
Nurse appointment		**LTC review soon**	
Tel call doctor		**LTC review when due**	