

Copies available in large print please ask at reception

BEDLINGTONSHIRE MEDICAL GROUP

PATIENT QUESTIONNAIRE

Please answer the following questions, which will provide useful information to your new GP. The answers will be strictly confidential, but if there is information that you would prefer to leave out, please tell the doctor or nurse at your first appointment.

To enable us to process your application to register quickly it would be helpful if you tell us your NHS number. You can obtain your NHS number from your previous GP surgery.

NHS Number:.....

Mr/Mrs/MissPlease state your full name)

Address

.....Post Code

Home Telephone No.....Work Telephone No.....

Mobile No..... (text messaging service available, please complete enclosed consent form if you wish to subscribe to this service)

Please ensure you inform us immediately of any change of address or telephone number

D.O.B..... Occupation

Have you served in the armed forces? YES/NO.....

Email Address:.....

Is English your first language? YES/NO If NO, what is it?

Do you have any major problems with your hearing, or vision?

Do you have any other disabilities?

What is your height?What is your last known weight?

Do you smoke? YES/NO IF YES, how many per day?.....

If Ex-smoker when did you stop and how many did you smoke per day?.....

Do you have a carer? YES/NO
 If YES, who?.....

Do you care for someone? YES/NO
 If YES, please give details.....

Are you taking any medication? YES/NO
 If YES please list them.....

Do you have any allergies/adverse reactions to medicines or other substances?
 YES/NO If YES, please list them.....

Do you have any allergies/adverse reactions to medicines or other substances?
 YES/NO If YES, please list them.....

Alcohol Intake Questions for patients aged 16 and over only

| Please circle your answer for each of the following questions | Pint of Regular Beer/Lager /Cider = 2 Units | Alcopop or Can of Lager = 1.5 Units | Glass of Wine (175ml) = 2 Units | Single measure of Spirits = 1 Unit | Bottle of Wine = 9 Units |
|--|---|-------------------------------------|---------------------------------|------------------------------------|--------------------------|
| | 0 | 1 | 2 | 3 | 4 |
| How Often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 9-10 |
| How often do you have 6 or more standard drinks on one occasion> | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

FOR WOMEN ONLY

Are you pregnant? YES/NO
 If YES, how many weeks?

Have you ever had a smear test YES/NO
 If YES, when was the last one?
 (breast screen)

PERSONAL HISTORY

Do **YOU** have any of the following?

| | Please tick here | Details |
|---------------------------------------|------------------|---------|
| Diabetes | | |
| High Blood Pressure | | |
| Heart Attack – Coronary Heart Disease | | |
| Angina | | |
| Stroke/Mini Stroke | | |
| Asthma | | |
| Cancer | | |
| Kidney Disease | | |
| Atrial Fibrillation | | |
| Obesity | | |
| Learning Disabilities | | |
| Epilepsy | | |
| Mental Health | | |
| High Cholesterol | | |
| Thyroid Trouble | | |
| Glaucoma | | |
| Disorders from birth | | |
| Other | | |

FAMILY HISTORY

Do any of your **FAMILY or CLOSE RELATIVES** have any of the following?

| | Please tick here | Details |
|---------------------------------------|------------------|---------|
| Diabetes | | |
| High Blood Pressure | | |
| Heart Attack – Coronary Heart Disease | | |
| Angina | | |
| Stroke/Mini Stroke | | |
| Asthma | | |
| Cancer | | |
| Kidney Disease | | |
| Atrial Fibrillation | | |
| Obesity | | |
| Learning Disabilities | | |
| Epilepsy | | |
| Mental Health | | |
| High Cholesterol | | |
| Thyroid Trouble | | |
| Glaucoma | | |
| Disorders from birth | | |
| Other | | |

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions. Choose ONE section from A to E, and then tick ONE box to indicate your background.

| A – White | | Please tick here |
|-----------------------------------|--|------------------|
| | British | |
| | Irish | |
| | Any other white background – Please detail below | |
| | | |
| B - Mixed | | |
| | White and Black Caribbean | |
| | White and Black African | |
| | White and Asian | |
| | Any other mixed background – Please detail below | |
| | | |
| C - Asian or Asian British | | |
| | Indian | |
| | Pakistani | |
| | Bangladeshi | |
| | Any other Asian background – Please detail below | |
| | | |
| D - Black or Black British | | |
| | Caribbean | |
| | African | |
| | Any other black background – Please detail below | |
| | | |
| E – Chinese or other ethnic group | | |
| | Chinese | |
| | Any other – Please detail below | |
| | | |
| | | |

Print Name: _____ Signature: _____

Date Completed: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

Office Use Only

ID Checked:

Photographic ID copied

State 2nd form of ID checked _____

Name: _____ Date: _____