**New Patient Questionnaire**

*(Please complete ALL sections of this form)*

**Section 1 - Personal Details**

*Title**Mr*□*Mrs*□ *Miss*□*Ms*□*Other* **□** *(please specify)*

*Name Date of Birth*

*Town of Birth Country of Birth*

***If Applicable (for those born outside the UK)***

*Reason for coming to UK Date of entry to the UK*

**Section 2 – Contact Details**

*Address*

*Telephone number(s) Mobile*

*How long have you lived at this address*

*Is this your permanent address?*

**Section 3- Ethnic Origin**

White □ Black other □ Chinese □

Black Caribbean □ Pakistani □ Vietnamese □

Black African □ Bangladeshi□ Indian □

Other

*What is your main spoken language?*

**Section 4 – Current GP Details**

*Name and address of your Current GP*

*Reason for changing doctor?*

**Section 5 – Family**

*Do you have any family members registered at Clifton Street Surgery?*

*Yes/ No*

*Please give details of those family members*

**Section 6 – Medical History**

***Do you suffer from any of the following illnesses?***

***(****Please circle which is appropriate)*

Heart Disease Yes/No Stroke/TIA Yes/No

Hypertension Yes/No Diabetes Yes/No

Epilepsy Yes/No Hypothyroidism Yes/No

Asthma Yes/No Depression Yes/No

Dementia Yes/No Chronic Kidney disease Yes/No

Chronic Obstructive Pulmonary Disease (COPD) Yes/No

Cancer Yes/No Please specify

*Other (please give details)*

**Section 7 – Current Medication**

*Please list all current medication:*

***Drug Name Strength Dose***

**Section 8– Other Information**

Are you:

* **A Carer –** (someone who looks after family, partners, friends or neighbours in need of help because they are ill, frail or have a disability.) **Yes/No**

*If you answered yes please give details of the person you care for and your relationship with them*

* **A Smoker Yes/No How many per day**
* **Ex-Smoker Yes/No When did you stop?**
* **Never Smoked Yes/No**

**Section 9 - Have you had Covid vaccination? Yes / No**

If yes, please give dates of vaccine:

1st Covid vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brand: AZ / Pfizer / Moderna

2nd Covid vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brand: AZ / Pfizer / Moderna

Please state where vaccine was given, eg, GP practice / Trust / SSE Arena

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 10 - Do you have any disability that means you would have difficulty accessing the surgery by telephone, eg, hearing loss? Yes / No**

If Yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need an interpreter? Yes / No

If Yes, please specify:

BSL (British Sign Language) Yes./ No

ISL (Irish Sign Language) Yes / No

Language (specify language) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You will be registered with the practice and not a specific doctor (due to NHS regulation changes from 1 April 2004). You do however have the right to state a preferred doctor or nurse. If you wish to state a preferred doctor or nurse, please do so below and we will record this on your records.

Preferred doctor or nurse

Signature Date

**DETAILS OF THE PRACTICE TEAM, HOW TO ACCESS THE SURGERY ETC ARE AVAILABLE ON THE PRACTICE WEBSITE:** [**WWW.CLIFTONSTREETSURGERY.COM**](http://WWW.CLIFTONSTREETSURGERY.COM)

**Office use ONLY**

**Does patient speak English without need for interpreter? Yes / No**

**If applicable, has patient been coded as living in Nursing or Residential Home? Yes / No**

Checked □

Signature Date