**New Patient Questionnaire**

*(Please complete ALL sections of this form)*

**PLEASE PROVIDE AN UP TO DATE PRINT OUT OF CURRENT REPEAT MEDICATION FROM YOUR CURRENT / PREVIOUS GP**

**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?*

**PLEASE NOTE THAT WE MAY USE YOUR MOBILE NUMBER TO SEND YOU TEXT MESSAGES ABOUT:**

APPOINTMENTS

SCREENING

VACCINATIONS

CHRONIC DISEASE REVIEWS

SMOKING STATUS

PATIENT EDUCATION

REQUEST TO CONTACT THE SURGERY

THIS LIST IS NOT EXHAUSTIVE

TEXTS WILL NOT NORMALLY BE USED FOR IMPORTANT ISSUES.

TEXTS WILL NEVER ASK FOR FINANCIAL INFORMATION OR ASK YOU TO ORDER ANYTHING.

**IF YOU WISH TO OPT-OUT OF TEXT MESSAGING, PLEASE INFORM A MEMBER OF STAFF.**

**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– 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 8 - 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 9 – PLEASE NOMINATE A PHARMACY WHERE YOU WILL COLLECT YOUR MEDICATIONS:**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**

**Is patient deaf / profoundly hard of hearing? Yes / No**

**If patient lives in a Nursing or Residential Home, has the PM been informed? Yes / No**

Checked □

Signature Date