SALTDEAN & ROTTINGDEAN MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

Please return completed questionnaire to the surgery, with proof of address (utility bill/bank statement)& photo ID

(MR/MRS/MISS/MS/OTHER…………………..) SURNAME……………………………………………………………………………..........

PREVIOUS SURNAME……………………………..……FORENAME/S……………………………………………………………………………

ADDRESS………

…………………………………………………………………………………………………....... POSTCODE………………………………………

DATE OF BIRTH……………………………………………………OCCUPATION……………………………………………………………

ETHNICITY ………………………………………………………………..WHAT IS YOUR FIRST LANGUAGE?.................................

DO YOU SPEAK ENGLISH? YES / NO IF NO DO YOU NEED A TRANSLATOR? YES / NO

TEL NO: HOME…………………………………......................MOBILE NO: ……………………………………………………………

PLEASE CIRCLE PREFERRED CONTACT NUMBER Home or Mobile

ARE YOU HAPPY FOR US TO LEAVE A MESSAGE? (YES / NO) (HOME / MOBILE / BOTH)

ARE YOU HAPPY TO RECEIVE SMS TEXT MESSAGES FROM THE SURGERY? YES / NO

E-MAIL ADDRESS ……………………………………………………..……………………………………………………

WOULD YOU LIKE TO REGISTER FOR ON-LINE SERVICES YES / NO

(IF YES PLEASE COMPLETE ‘ON-LINE’CONSENT FORMS INCLUDED IN REGISTRATION PACK)

HAVE YOU READ THE SUMMARY CARE RECORDS INFORMATION ? YES / NO

(COPY AVAILABLE AT RECEPTION)

ARE YOU HAPPY YOUR SUMMARY CARE RECORD TO GO ON THE SPINE ? YES / NO

Please circle if you would like to collect your prescription from:

SURGERY / BRIDGMANS / COOP / HEALTHY-U / LLOYDS, ROTTINGDEAN / LLOYDS, SALTDEAN

OTHER (please give details)…………………………………………………

DO YOU GIVE YOUR CONSENT FOR PRESCRIPTIONS TO BE SENT ELECTRONICALLY TO YOUR CHOSEN PHARMACY YES / NO

NEXT OF KIN :-

Name……………………………………………………………………..…………………Relationship……………………………………..………

Address………….……………………………………………………………………………Postcode…………………..………………………………..

Contact telephone number……PTO

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HEIGHT ……….ft……….ins…….. / metres……..   WEIGHT ………..st………..lbs / ……….kg

SMOKER?   YES   EX SMOKER   NEVER   E-CIGARETTES   If you smoke how many cigarettes/oz per day…………

Do you drink alcohol?   YES / NO   If yes how many units per week?............

(1 unit =a glass of wine ***or*** half a pint of beer/lager ***or*** a pub measure of spirits)

<u>YOUR PAST MEDICAL HISTORY -</u> Have you ever suffered from (please circle)

ASTHMA/COPD   DIABETES   ECZEMA   EPILEPSY   GLAUCOMA/BLINDNESS

HAY FEVER   HIGH BLOOD PRESSURE   STROKE/TIA   HEART ATTACK/ANGINA

CANCER   THYROID DISEASE   MENTAL ILLNESS

DO YOU HAVE ANY ALLERGIES TO ANY DRUGS or SUBSTANCES?   YES / NO

If yes please give details ………………………………………………………………………….

<u>PLEASE DETAIL ANY MEDICAL CONDITIONS YOU HAVE HAD</u>

(please include admissions to hospital, operations, major illnesses)

……
……
……
……

<u>DRUGS and MEDICINES</u>

Are you taking any regular medication? If so please detail the names & dosages :-

……
……
……
……
……

Are you a carer for someone?   Yes   /   no

Do you have a carer?   Yes   /   no

If yes

Name of Carer or Agency……………………………….   Contact details for Carer or Agency…………………………………………………..

<u>FOR PRACTICE USE ONLY:-</u>

PHOTOGRAPHIC ID   Passport   Driving Licence   Other

PROOF OF ADDRESS   Utility Bill   Bank letter/statement   Mortgage/Tenancy agreement

Council Tax Bill   Other

Reviewed JUNE 2019