Strensall Medical Practice - New Patient Questionnaire

Please complete in CAPITALS with black or blue ink

Your Details

Date: .....

Name: .....

Date of Birth: ..... Tel No: .....

Occupation: ..... Mobile Phone No: .....

Ethnic Background: ..... First Language: .....
(e.g. Asian, black African, Chinese, white, mixed white/African, etc.)

Do you look after someone? YES / NO Does someone look after you? YES / NO

Registration

Have you been registered with the Practice before? YES / NO

How did you become aware of Strensall Medical practice? .....
(e.g. Word of mouth, internet search, previously a patient, etc.)

Health History

Date	Illnesses, accidents or operations	Date	Illnesses, accidents or operations
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Current Medicines Give names and dose

....

....

....

..... Drug Allergies: .....

....

Alcohol

Questions: Score:	0	1	2	3	4	Your Score:
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	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking

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Smoking status

Have you ever smoked? YES / NO

If YES, do you smoke now? YES / NO Cigarettes per day: …….. Pipe/cigars: ……..

Women Only

Cervical Smear (most recent test):

Date: ..... Result: ..... If not at GP surgery please specify: .....

Please hand in at Reception, thank you

16Feb12 v2