

WELLS ROAD SURGERY

NEW PATIENT QUESTIONNAIRE

Please answer all questions

Surname **First Names**.....

Title **DOB**

Telephone No. Land Line **Mobile**

Address.....

Marital Status Single/Married/Separated/Divorced/Widowed/Other

Occupation.....

Next of kin & Contact Number

What serious illnesses have you had

.....

What operations have you had.....

.....

Do you have any problems at the moment

.....

Please list any allergies you have

.....

**Please list any tablets, medicines or other treatments you are taking
(including those bought from a chemist)**

.....

Do you smoke Yes/No If yes, how much do you each day.....

What do you smoke e.g. Cigarettes, Pipe, Cigars

Have you ever smoked Yes/No. If yes when did you give it up

What sort of exercise do you take.....

How long do you do this exercise for (in minutes)

Do you exercise less than once/once/twice/3 times per week/every day

About your alcohol consumption

A pint of Beer/Lager/Cider/ 175mls glass of Wine is 2 units

Bottle of wine is 9 units

A single measure of spirit is 1 unit

Alcopop or Can of Lager 1.5 units

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times / month	2 - 3 times / week	4+ times / week	
When you are drinking how many standard alcoholic drinks do you have in a typical day?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard (units) drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily / almost daily	

Please describe any special diet you are on

Would you describe your diet as high/medium/low fat

How tall are you**What is your weight**.....

Are you allergic to any medication

What effect does the medication have on you

Have you or a close relative ever suffered from(e.g. mother, father, grandparents)

High blood pressure Heart Attack

Angina Stroke

DiabetesThyroid Problems

Cancer TB

When did you last have a tetanus injection

QUESTIONNAIRE FOR CARERS

ARE YOU A CARER YES / NO

Aged over 16 years? YES / NO

In receipt of carers or attendance allowance YES / NO

Providing practical support which is essential on a daily basis YES / NO

Your care would need to be replaced by other Services with 24 hours if you became ill YES / NO

PATIENT PROFILING FORM

What do you consider to be your ethnic origin?

Asian of Asian British

- Bangladeshi
- Indian
- Pakistani
- Asian other (please state)

White

- British
- Irish
- White other (please state)

Black or Black British

- African
- Somali
- Caribbean
- Black other (please state)

Other Ethnic Group

- Chinese
- Any Other (please state)

Mixed Background

- White and Asian
- White and Black African
- White and Black Caribbean
- Other mixed background (please state)

In the surgery, which language do you usually speak and read?

Speaking Reading

- English
- Albanian
- Bengali
- Cantonese
- Farsi
- French
- Gujarati
- Hindi
- Mandarin

Speaking Reading

- Polish
- Punjabi
- Russian
- Somali
- Spanish
- Turkish
- Urdu
- Other

Thank you for helping us

- I do not wish to complete the patient profiling form

PLEASE NOTIFY THE PRACTICE IF YOU CHANGE YOUR ADDRESS AND/OR TELEPHONE NUMBER OR IF YOU ARE LEAVING THE COUNTRY. IT IS VERY IMPORTANT TO KEEP YOUR MEDICAL RECORDS UP TO DATE. IF MAIL IS SENT OUT TO YOU AND RETURNED, YOU WILL BE REMOVED FROM THE PRACTICE LIST