**SHERE SURGERY & DISPENSARY**



Dr C Knight Salaried Doctor:

Dr E Watts Dr A Bissell

Dr D Wardrop

Dr M McEwen

Dr Helen Barnes

**NEW PATIENT QUESTIONNAIRE:**

Please complete this questionnaire, as it will help us to help you until your records arrive from your previous doctor.

Preferred Title:

Surname:

Forenames:

Marital Status:

Occupation:

Town of birth:

Country of birth:

Nationality:

Date of birth:

Age:

Gender: Male [ ] Female [ ]

Other [ ]

Height:

Weight:

Current Address: Previous Address:

Post code:

Home telephone number:

Mobile telephone number:

Email address:

Next of kin: …………………………………………… Tel. No:. ……………………………..

Relationship:………………………………………….

Are you a career? Yes [ ] No [ ] If yes who do you care for?……………………………

Relationship:…………………………………………………………………………………..

Do you have any allergies? Yes [ ] No [ ]

If yes, please list: Drugs: ………………………………………….

………………………………………….

Others: ………………………………………….

………………………………………….

Are you on a special diet? Yes [ ] No [ ]

If yes please specify ……………………………………………………………..

**Please turn over**

Do you smoke? Yes [ ] / No [ ] : Cigarettes [ ] Cigars [ ] Pipe [ ]

How many do you smoke each day? ……………………………………………

If you smoked in the past, when did you stop? …………………………………

Have you or a close blood relative under the age of 60 suffered from any of the following? If yes please state if self or which relative

Heart Attack: Yes / No ….……….. Cancer: Yes / No …………………

Diabetes: Yes / No …………………….. High BP: Yes / No …………………

Stroke: Yes / No …………………….. Tuberculosis: Yes / No …………………

COPD: Yes / No …………………….. Thyroid problem: Yes / No ….................

Strok

Please list any current medication or attach repeat slip:

|  |  |  |
| --- | --- | --- |
| Drug | Strength | Dose |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**If you have regular,** **prescriptions please make a New Patient appointment for a review with a GP or Nurse, to enable us to organise repeat medication.**

If you would like to attend a new patient health check please speak to Reception.

Please give detail and date of any conditions, operations or serious illnesses you have had:

Do you or your carer have any communication/information needs relating to a disability, impairment or sensory loss and, if so, what are they?

Would you like a Summary Care Record? Yes [ ] No [ ]

*In event of emergency, it allows other health care providers access to any pre-existing conditions and medication*

Would you like to receive text reminders for appointments? Yes [ ] No [ ]

*(This may include relevant Health Questionnaires from time to time.)*

*`*

Please ensure you have read and fully understand the information regarding these services.

How many units of alcohol do you drink each week?............................. units

(1 unit = ½ pint beer = 1 single spirit = 1 glass of wine. If none put NIL)

How often do you have a Never Monthly 2- 4times 2-3 times 4+ times

drink that contains alcohol? or less per month per week per week

How many standard alcoholic

drinks do you have on a typical 1-2 3-4 5-6 7-9 10+

day when you are drinking?

How often do you have 6 or more Never Less than Monthly Weekly Daily or almost

Standard drinks on one occasion monthly daily