DENTON MEDICAL PRACTICE

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NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with Denton Medical Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. [Note: if there is a requirement for patients to attend a new patient assessment, give details here]

Surname: ……

Forename(s): ……

Date of Birth: ……

Marital status: ……

Address: ……

……

Postcode: ……

Home tel: ……

Mobile: ……

Email address: ……

Occupation: ……

Weight (approx): …… Height: ……

Date of completion of this form: ……

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SMOKING

Do you smoke? Yes / No

If Yes, how many:

Cigarettes per day …….. Cigars per day ……..

Ounces of tobacco per day ……..

How old were you when you started smoking? ……..

EX-SMOKERS

How old were you when you stopped smoking? ……..

How much did you smoke per day? ……..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

For the following questions please circle the answer which best applies
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No *Yes on one occasion* *Yes on more than one occasion*

DIET

Do you add salt to your food after cooking? Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise? ……

How many times per week? ……..

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? ……..

Stroke? Yes / No Which family member? ……..

Cancer? Yes / No Which family member? ……..

Site of cancer? ……..

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……..

Dosage: ……..

Name of drug: ……..

Dosage: ……..

Name of drug: ……..

Dosage: ……..

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details: ……

……

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

……

Please give details of any treatment for any chronic medical conditions:

……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

……

IMMUNISATIONS

Dates of Triple/polio/HIB:

……

Dates of MMR:

……

Date of last Tetanus:

……

FEMALE PATIENTS

Date of most recent cervical smear: ……

Result of most recent smear: ……

Please give details of any complications in pregnancy:

……

……

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer?

Yes / No

If “Yes”, would you like them to deal with your health affairs here?

Yes / No

(the receptionist can help with these arrangements)

Do you care for anyone else?

Yes / No

If “Yes”, ask the receptionist about Carers support

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

Name .....

Date of Birth .....

A **White**

	British
	Irish
	Any other white background please write in below

B **Mixed**

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C **Asian or Asian British**

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D **Black or Black British**

	Caribbean
	African
	Any other black background please write below

E **Chinese or other ethnic group**

	Chinese
	Any other please write below

Declined	

First Language

DENTON MEDICAL PRACTICE

Tameside and Glossop Primary Care Trust (PCT) wants to make sure that the information that we hold about you is accurate and is a clear record of the care and treatment you have received. We also want to check to ensure that the quality of care you receive is of the right standard. Access to patient information is also required to check that proper payments have been made to your GP. To enable the PCT to do this, they need to be able to look at the information held in your records here at the surgery.

The people who carry out any audits on patient records are working within the NHS and are, therefore, bound by its Code of Confidentiality (2003). Sometimes clinicians from outside the practice may also need to look at the records and they are bound by professional codes of responsibility.

If you require any further information on the use of your information, please contact the PCT Clinical Governance Team on 0161 304 5411.

Please note that you can withdraw your consent at any time at this practice.

If you agree to the PCT looking at your records, please complete the section below.

I give my consent to allow access to my records for the purposes described in this letter.

Name: ……

Date of Birth: ……

Signature: …… **Date:** ……

To be completed by the practice

Date Read Code 9Nd4 entered on system: ……

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