WEST BAR SURGERY

New Patient Questionnaire

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**	
Mr / Mrs / Miss / Ms / Other……..					**Work Number**	
Address and Postcode					**Mobile Number:**	
					E-mail Address:	
					Next of Kin:	
					Relationship to you:	
Date of Birth:		**Previous / Mother's surname if different:**			**Next of Kin Contact Number**	
Marital Status:		**Gender:**	**Male:**	**Female:**	**Town & Country of Birth**	
Occupation:					**NHS Number (if known)**	
Previous Address					**Previous Postcode:**	
					Previous Doctor Telephone No.	
Previous Doctor Name & Address:					**If applicable, date you first came to live in Britain:**	
If returning from Armed Forces:		**Your Service or Personnel Number**			**Your Enlistment Date**	
Your height:	**Feet / inches**	**cm**	**Your weight:**		**Stones / lbs.**	**kg**
Your Blood Pressure	**Systolic**	**Diastolic**				

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	White (UK)	White (Irish)	White (Other)
Caribbean	African	Asian	Other Mixed
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other	Ethnic Category not stated

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish / Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / ozs of tobacco do you smoke in a week?			*If you are a smoker and want to stop, please ask for information about local smoking cessation services.*		

Alcohol - How much do you drink? **(AUDIT C)**

Questions	Scoring System 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

If you require advice regarding your alcohol consumption - please ask at reception

Your Medical Background:	
Please list any serious illnesses/operations/accidents/ disabilities (and for women any pregnancy related problems) and the year they took place	

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**		
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**	
	Thyroid Disorder		**Any other important Family Illness?**			

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Specific Needs: **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:**	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Signed:** **Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? If yes please provide a copy.	**Yes / No**	**If "Yes", please state their name / address / phone number:**

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be sent to you.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**
Do you want to register for on-line ordering of repeat medication	**Yes / No**
FOR PATIENTS AGED 18 or UNDER ONLY	
This Practice actively supports Child Protection Policies in Oxfordshire which requires us to record whether you (if over 16 but under 18) has ever had a Social Worker involved with your family?	**Yes / No**

Parents/Guardian Name, Address and Telephone No.	

Patient Signature:		**Signature on behalf of Patient:**	

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.westbarsurgery.co.uk

For Practice Use only **ID Seen: Yes No** **Address Confirmed: Yes No**

Form Checked by (Print Name):_____