

Your Drinking/Alcohol Consumption

(Average UK units below)



I would prefer not to disclose my alcohol consumption

How much alcohol do you drink per week? (in units, see above)

Please answer the questions below: write your scores in the boxes at the side

A total score of 3 or more indicates hazardous or harmful drinking.

Score →	0	1	2	3	4
How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Only complete the following questions if you answered monthly (scored 2) or less above					
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative / friend / Doctor / health worker been concerned about your drinking and advised you to cut down?	Never		Yes but not in the last year		Yes during the last year

Carers

Are you a Carer? Yes No

Do you have a Carer? Yes No

Who Do You Care For:

Who Cares For You:

Their Address:

Their Address:

Post Code:

Post Code:

Phone Number:

Phone Number:

Your Emergency Contact

Mr/Mrs/Miss/Ms/Other → ()

Relationship To You:

First/Given Name:

Last/Family Name:

Their Address:

Post Code:

Home Phone:

Mobile Phone:



The Coastal Partnership

New Patient Questionnaire

The information that you provide on this form will be handled in the **strictest confidence** by both your clinician and the Practice to get to know you and your medical history. Please return the completed form to the surgery as soon as possible.

PLEASE USE CAPITALS & BLACK INK TO COMPLETE THIS FORM

About You

Mr/Mrs/Miss/Ms/Other → () Date of Birth:/...../.....

First/Given Name: Last/Family Name:

Marital Status: Married Single Widowed Re-married
Divorced Separated Co-Habiting Civil P'ship

Your Home Address:

Post Code:

Home Phone: Mobile Phone*:

Ethnic Origin: First Language:

Occupation:

Previous Doctor's Details Name:

Practice Address:

Post Code:

Have you ever been registered with this Partnership before? Yes

If you are over 11**, would you like online access to manage your healthcare? Yes

You can book appointments, request repeat medication, access your coded medical record, etc.

Preferred pharmacy for electronic prescriptions (EPS):

Please ask for or download the leaflet

for further information about EPS.

Appliances:

Your Current Medication

Please attach a separate sheet, if required, of your current medication, which includes: name of drug/medicine; strength (e.g. 10mg, 20mg, etc.) and dosage (i.e. times per day).

If you are on any regular medication, please make an appointment for a check.

Please bring along any repeat medication slips that you may have from your previous Doctor.

*By providing your mobile number, you consent to receiving text message reminders for appointments and/or Practice medical campaigns (e.g. Flu vaccine). Please let your surgery know if you would prefer not to receive these messages. Your mobile number will not be used for any other messaging purpose or passed onto any other organisations.

We securely share your information with other services treating you; please see "Practice Standards->Confidentiality..." on our website for further information. If you do not have access to the internet, please ask at reception. **A competency will be required (performed by a clinician) for patients aged 11-15.

Please turn to page 2 →

Do you have any of the following medical problems?

Tick all those appropriate, and please provide the **year** (if known).

<input type="checkbox"/> High Blood Pressure	Year ()	<input type="checkbox"/> Angina/Heart Attack	Year ()
<input type="checkbox"/> Over/under active thyroid	()	<input type="checkbox"/> Gastritis/Peptic ulcer	()
<input type="checkbox"/> Arthritis/Gout	()	<input type="checkbox"/> Asthma	()
<input type="checkbox"/> Diabetes (insulin dependent Y/N)	()	<input type="checkbox"/> Mental Illness/Depression	()
<input type="checkbox"/> Lung Disease/Bronchitis	()	<input type="checkbox"/> Epilepsy	()
<input type="checkbox"/> Cancer ()		
<i>(please specify)</i>			
<input type="checkbox"/> Other Problems ()		
<i>(please specify)</i>			
 ()		

Your Allergies

Are you allergic or sensitive to any medication, food, animals, etc.?

Your Immunisations

Have you been immunised against any of the following? If so, please give dates.

Tetanus Yes No → if Yes → Date:/...../.....

Influenza (Flu) Yes No → if Yes → Date:/...../.....

Pneumococcal Yes No → if Yes → Date:/...../.....

Your Smoking – We strongly advise that you do **NOT** smoke

I would prefer not to disclose my smoking status

Have you ever smoked? Yes No
 → if Yes, do you smoke now? Yes No → if No, when did you stop?/...../.....

→ ...or if Yes, do you smoke cigarettes/cigars/pipe/roll your own, and how much?

Cigarettes (per day)

Cigars (per day)

Pipe / Roll Your Own (ounces / grams per week)

If you currently smoke and would like help giving up, would you like us to help you? Yes No

Your Memory

Are you worried about your memory? Yes No → if Yes, please give details here

Accessible Information Standard

Do you require help with information? Yes No → if Yes, please give details here
(e.g. different formats, Braille, email, large print, sign language, etc.)

Your Family History

Do you, or any of your family or close relations, have any of the following conditions?

Tick all those appropriate, and please write beside the family member affected.

Please include any brother(s) or sister(s) and any serious illnesses they may have suffered.

Sugar Diabetes	<input type="checkbox"/>	→	Who:
High Blood Pressure	<input type="checkbox"/>	→	Who:
Heart Attack	<input type="checkbox"/>	→	Who:
Asthma	<input type="checkbox"/>	→	Who:
Anxiety Disorders	<input type="checkbox"/>	→	Who:
Nervous System Disorders	<input type="checkbox"/>	→	Who:
Congenital Diseases	<input type="checkbox"/>	→	Who:
Epilepsy / Fits	<input type="checkbox"/>	→	Who:
Cancer	<input type="checkbox"/>	→	Who:
Other Diseases <i>(please specify)</i>			
.....	<input type="checkbox"/>	→	Who:
.....	<input type="checkbox"/>	→	Who:
.....	<input type="checkbox"/>	→	Who:

No Relevant Family History

Are your parents still alive and in good health?

Mother: Father:
(if either have died, please could you say how old they were when they died and what the known cause of death was, in the box below)

If you have any specific health issues that you would like to discuss, please give details below and you will be contacted by one of our Nurses.

Women Only

Have you had a cervical (cancer) smear: Yes No

→ If Yes, what date was your last smear:/...../.....

Where did you have the smear taken: Doctor / Clinic / Private / Hospital *(circle as appropriate)*

Have you had a hysterectomy? Yes No → if Yes, what year: