WELCOME TO OUR SURGERY

NEW PATIENT QUESTIONNAIRE – ADULT

All information provided will be treated in the strictest confidence

PERSONAL DETAILS

IF BORN OUTSIDE THE UK, PLEASE GIVE DATE OF ENTRY .....

HAVE YOU BEEN REGISTERED AT THIS SURGERY BEFORE: YES/NO

Surname:.....**First Name(s)**: ..... **M/F**

Former Name: .....**Date of Birth**: ..... **Place of Birth**: .....

Marital Status:.....**Occupation**:.....

Number of Children, *if any*: . ..... **Surname *(If different to yours)***: .....

Current Address: .....

Post Code: .....**Tel**: .....**Mobile**: .....

Email Address:.....

Name & Address of Previous Doctor:.....

.....

NHS number, *if known*:.....

Langley Corner Surgery provides a Text Message appointment confirmation and reminder service. If you tell us your mobile number you will be opted-in to this service. We will TEXT MESSAGE invitations for some clinics and services, and to patients who don't attend an appointment that has not been cancelled.. Please tick this box if you do NOT want to receive Text Messages from us ☐

MEDICAL DETAILS

QUESTIONS	ALCOHOL SCREENING - 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 per month*	*2-3 times per week*	*4+ times per week*	
How many units of alcohol do you drink on a typical day?	*1 – 2*	*3 – 4*	*5 - 6*	*7 - 8*	*10+*	
How often do you have 8 or more drinks on one occasion?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost Daily*	

Pint of beer/lager/cider/glass of wine = 2 units Alcopop/Can of beer/lager = 1.5 units Single spirit measure= 1 unit

If you score 5+, this may mean hazardous or harmful drinking, so we will offer you a healthy lifestyle appointment with a Healthcare Assistant to discuss support and guidance. ***Please tick the box if you do NOT want this service*** ☐

Is there anything else we should know about you, such as disabilities, information needs or other special communication needs? .....

.....

Have you ever smoked? Yes/No **Do you smoke now**? Yes/No **How many cigarettes/cigars a day**?.....

Are you an ex-smoker? Yes/No **If so when did you give up?**:.....

Please attach your repeat prescription slip if you have one.

Please list any allergies:.....

Please list any serious health problems you have had: .....

.....

NEXT OF KIN

Name:.....**Relationship**: .....

Address: .....

Post code: .....**Tel**: ..... **Mobile**: .....

Have you appointed a Health & Welfare Attorney? Yes/No

If yes, please give details:.....

Do you have an Advance Directive ("Living Will") in place regarding your treatment? Yes/No

If yes, please give details:.....

Do you agree to a named person to speak to us on your behalf or have access to your records? Yes/No

If yes, please complete the consent form at Reception

DIVERSITY MONITORING INFORMATION (please tick the box which best describes your cultural& ethnic origin)

☐ White British	☐ Black British	☐ Indian
☐ White Irish	☐ Black Caribbean	☐ Pakistani
☐ White European	☐ Black African	☐ Bangladeshi
		☐ Chinese
☐ Other white origin Please specify:	☐ Other black origin Please specify:	☐ Other Asian origin Please specify:

Please tick if you would prefer NOT to state your ethnicity ☐

What is your first language? .....