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HADLEIGH BOXFORD GROUP PRACTICE
New Patient Questionnaire

To be completed by the person applying to register or their parent/guardian.
Please complete both sides of this form in BLOCK CAPITALS
This form is also available on our website www.hadleighhealth.co.uk

Title: Mr / Mrs / Miss / Ms / Dr / Other (please state) **Marital Status:**

Last or Family Name: **First Name(s):**

Date of Birth: **Occupation:**

Address:

Postcode: **Email:**

Telephone numbers – Daytime: **Evening:** **Mobile:**

Are you happy to receive text messages from us? (appointment reminders etc) Y☐ No ☐

Preferred method of contact Letter (default) Email SMS (please circle)

ETHNIC ORIGIN

What groups do you mostly identify with? *Please tick only ONE box in Section A and ONE box in Section B.*

Section A

☐ British or Mixed British
☐ English
☐ Irish
☐ Scottish
☐ Welsh
☐ Other *(please specify)* _____

Section B

ASIAN

☐ Bangladeshi
☐ Indian
☐ Pakistani
☐ Other (*please specify*)

_____

BLACK

☐ African
☐ Caribbean
☐ Other (*please specify*)

CHINESE

☐ Any (*please specify*)

_____

MIXED ETHNIC BACKGROUND

☐ Asian and White

☐ Black African and White
☐ Black Caribbean and White
☐ Other (*please specify*)

WHITE

☐ Any (*please specify*)

_____

OTHER BACKGROUND

☐ Other (*please specify*)

_____

Are you housebound? Yes ☐ No ☐ | **Are you a Carer?** Yes ☐ No ☐

Do you have a Carer? If yes, please give a name and telephone number

Would you like your carer to deal with any health affairs on your behalf?
Yes ☐ No ☐

Name, address and contact telephone number of Next of Kin: *(Please state whether parent/son/daughter etc)*

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Do you suffer from any of the following? Or does an immediate family member where indicated?		
Conditions	**You**	**Family*(tick only if a parent/son/daughter/brother/sister)***
Asthma or COPD	Yes ☐ No ☐	
Cancer	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Yes ☐ No ☐
Thyroid problems	Yes ☐ No ☐	
Stroke	Yes ☐ No ☐	Yes ☐ No ☐
Angina/Heart Attack	Yes ☐ No ☐	Yes ☐ No ☐
Blood Pressure	Yes ☐ No ☐	
Kidney Problems	Yes ☐ No ☐	
Have you received treatment for depression?	Yes ☐ No ☐	

ALCOHOL

Alcohol units per week … (1 unit = ½ pint beer, lager or cider, 1 small glass of wine, 1 pub measure of spirit)

And each of these is more than one unit …

Pint of regular beer/larger or cider = 2
Pint of premium beer/larger or cider =3
Alcopops = 1.5
Can of premium lager or strong beer = 2
Can of super strength lager = 4
Glass of wine = 2
Bottle of wine = 9

A) How often do you have a drink containing alcohol?

Never ☐ Monthly or less ☐ 2-4 times a month ☐

2-3 times a week ☐ 4 or more times a week ☐

B) How many units of alcohol do you have on a typical day?

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐

C) How often do you have 6 units or more on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

WEIGHT

Height:	Weight:	BMI:

SMOKING

Do you smoke? Yes ☐ No ☐ If YES, how many per day? _____

Have you smoked before? Yes ☐ No ☐ If YES, when did you stop? _____
Would you like help or advice about giving up smoking? Yes ☐ No ☐

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ADDITIONAL INFORMATION		
Women's Health		
Are you pregnant?	Yes ☐ No ☐	
Have you had a hysterectomy?	Yes ☐ No ☐	If yes, when?
Allergies		
Do you have an allergic reaction e.g. rash/collapse, to any medication and/or eggs?	Yes ☐ No ☐	If yes, please specify
Please attach a printed list of repeat medication from your previous surgery or list below. State "NONE" if you are not on any repeated medication.		
NAME of Medication *(also state in what form e.g. tablets/capsules/liquid/inhaler)*	**DOSE?** *i.e. one a day / 2 puffs four times a day.*	**What complaint is it taken for?**

To ensure that we include patients in all relevant Health Care Programmes you will be asked to have a 20 minute registration appointment with a clinician. Please tick to confirm you are happy to attend a new patient check consultation ☐

If you are asked, or wish to attend a registration appointment this must be completed within 2 months.

GP Practices are now asked as part of the contract changes for 2015-2016 to provide all our patients with a named GP who will have overall responsibility for the care and support that our surgery provides to them. As one of our patients, you have been allocated a named GP who will have overall responsibility for the care and support our surgery provides to you and will work with other healthcare professionals who are also involved in your care, to ensure that it meets your individual needs. This does not prevent you from seeing any other clinician in the practice.
Tick read ☐

Patient signature..... Date .....
or the signature of Parent/Guardian if on behalf of patient

IDENTIFICATION SEEN – Driving Licence / Utility Bill / Passport (please circle)
Receptionist to sign confirmation of ID seen

Receptionist signature …….. Date……

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Hadleigh Boxford Group Practice

ONLINE SERVICE REGISTRATION - FOR NEWLY REGISTERED PATIENTS

Please return this slip if you wish to sign up for Online Services (see leaflet attached with registration pack) This service now includes prospective access to your full record (date you registered with our surgery) and can be activated after your registration is accepted, normally takes 1-3 weeks.

I wish to sign up for the Online Services

Name & Address:

Date of Birth:

Date you registered with surgery:

Signed……

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