JOHN TASKER HOUSE & FELSTED SURGERIES

NEW PATIENT QUESTIONNAIRE

YOU ARE REQUIRED TO PROVIDE SUITABLE PROOF OF RESIDENCE (I.E. UTILITY BILL OR DRIVING LICENCE) WITH YOUR COMPLETED REGISTRATION FORM.

1)	PATIENT DETAILS: (please use CA	PITAL LET	TTERS)								
	FULL NAME:			DATE	OF BIRTH dd/mi	m/yyyy:	1 Phone				
	CONTACT TEL NO:		EN	MAIL:							
2)	ETHNICITY: British \(\Bar{\cup} \)	1ixed Brit	ish 🗌 🛮 Oth	er (Please sta	te)						
	Main language (if not English)										
	Which is your main language? Do you speak English? Yes / No										
	,				do you need a tr	~					
3)	SMOKING STATUS				ao you need a th	unsidion. 10.	, , , , , ,				
	Do you smoke? Yes ☐ / No ☐]	If ye	es, how many	cigarettes do yo	u smoke dail	v?				
	If no, have you smoked in the pas	t? Yes		· ,	Do you use ele						
4)	HEIGHT/WEIGHT What is you	r weight:		_ kg/stone	Height:	cm/fe	et & inches				
5)	ALCOHOL INTAKE Teetotaller		One unit of alcohol	Half pint of "regular" boer, lager or cider	Haif a small glass of wine 1 sin	igle 1 small glass of sherry	1 single measure of aperitins				
	Questions			Scoring sys	tem	You					
		0	1	2	3	4	score				
	How often do you have a drink	Never	Monthly or	2-4 times	2-3 times per	4+ times					
	that contains alcohol?		less	per month	week	per week					
	How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+					
	How often do you have 6 or	Never	Less than	Monthly	Weekly	Daily or					
	more standard drinks on one		monthly			almost					
	occasion?		-			daily					
6) 7)	CARER STATUS Are you a Carer? □ Do you I NEXT OF KIN(S) Name & Relations		reŕ? ☐ Na								
')											
	Contact Telephone(s):										
3)	CONTACTING YOU: We will use yo services which may be of benefit Letters to your home address		edical care D	o you consen		to send:	and other				
∌) _	SUMMARY CARE RECORD (SCR)										
	For more information: Phone 030 All patients registered with a GP h Record contains basic information medication in the past. Go to our	nave a SCF n about al	R, unless they lergies, medic	have chosen i ations, and ar	not to have one. ny reactions that		•				
	A. I would like to include additi	onal info	rmation in my	SCR 🗌							

DISABILITIES / ACCESSIBLE INFOR Do you have any special commun	ication	nood	-O Vacl					
To you have any special community \Box	icatioi	i ileeu: R	lind/nart	ally sighted? \Box			Hearing	problems
Housebound L		J	ma, pare	uny signiture:				
FAMILY HISTORY AND PAST MED	CAL H	ISTOR	Y :				T	
Condition	~	Relat	ionship	Condition			Relation	nship
Heart Attack/Angina – under 60				Asthma		ᆜ		
Heart Attack/Angina – over 60	<u> </u>			Epilepsy				
Stroke	ᆜ			Cancer		ㅁ		
Diabetes	14			Rheumatoid Arth	ritis	Ш	-	
High Blood Pressure								
enter details below: Condition	Y	'ear	Ongoin	Condition			Year	Ongoin
Condition	<u> </u>	ear	Ongoin	Condition			ı cai	
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MEDICATION: If you require REPI medication boxes showing your o	AT mo	edicati so tha	on(s), ple t this can	ise provide the prescr be input onto your re	cords.			
ALLERGIES: Please list any drug o MEDICATION: If you require REPI medication boxes showing your o PRACTICE CHARTER At our surgery we aim to provide	EAT molecular management of the second secon	edicati so tha atients	on(s), ple t this can	ise provide the prescr be input onto your re- best quality care avail	cords. able. (Our o	charter is a	
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If you feel it is necessary to permit Proxy to a trusted person, to allow access to your records (i.e. to order medication on your behalf). You will be asked to complete a form which will then be passed to a GP to assess your status and authorise accordingly.