**Welcome to Cantilupe and Hampton Dene Surgery**

**New Patient Questionnaire**

Name: ………………………………………………………….. Date of Birth …………………………………………………

Address ……………………………………………………………….. Home phone …………………………………………

Mobile number ………………………………………. Email address: …………………………………………………….

What is your preferred method of communication? ………………………………………………………………

Nationality …………………………………………………… 1st language …………………………………………………..

2nd language …………………………………………………… do you need an interpreter Yes/No?

Do you smoke? Yes/no if yes how many per day …………………………………………………………..

**We strongly advise patients to stop smoking – please ask for details of “stop smoking services” available in Herefordshire**

Have you ever smoked, if so when did you give up? ………………………………………………………………

What is your approximate weight? ......................... What is your height? ……………………………..

**Current Health**

Do you have any long term conditions or serious illness e.g. diabetes, asthma, heart disease, COPD or have you had a stroke or TIA etc.? If so please list below:

………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………

Are you on any repeat medication? If you are, please list below with strength and dose if known, or attach a copy if you have a print out from your previous doctor.

……………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………….

Do you have any allergies? Yes/No if yes to what? .....................................................

**Ladies only**

Are you pregnant? Yes/No When did you have your last smear? …………………….

Have you had a hysterectomy? Yes/no If so when? ...............................................................

**All to answer over 16 years of age**

Do you drink alcohol? – Please circle answers that apply to you.

How often do you have a drink that contains alcohol?

Never (0)

Monthly or less (1)

2-4 times a **month** (2)

2-3 times a **week** (3)

4+ times a **week** (4)

How many units of alcohol do you have on a typical day when you are drinking?

1-2 (0)

3-4 (1)

5-6 (2)

7-8 (3)

10+ (4)

(1 unit= ½ pint normal strength beer or cider, 1 small glass wine, 1 pub measure of spirit)

How often do you have 6 or more units (female) or 8 or more units (male) on one occasion?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily (4)

If your scores add up to 5 or more you appear to be drinking more than recommended levels and will receive further information in the post.

**Family history (immediate family or close relations)**

Do you have any family history of any of the following? (please circle all that apply and which relative)

Heart problems ……………………………………………………………………………………………………………………..

Stroke ……………………………………………………………………………………………………………………………………

Asthma ………………………………………………………………………………………………………………………………….

COPD (chronic obstructive pulmonary disease) ……………………………………………………………………..

Kidney disease ……………………………………………………………………………………………………………………….

Epilepsy/fits …………………………………………………………………………………………………………………………..

High blood pressure (hypertension) ………………………………………………………………………………………

Depression/anxiety ……………………………………………………………………………………………………………….

Cancer …………………………………………………………………………………………………………………………………..

Skin problems ………………………………………………………………………………………………………………………..

Other (please specify) …………………………………………………………………………………………………………..

Have you ever served in the armed forces (even for 1 day)? Yes/No

**Do you care for another person (without pay) who, because of their disability or effects of age cannot manage at home without help?** Yes/No

If yes are they a patient here? Yes/No

If yes could we have their name & address and relationship to you? …………………………………….

…………………………………………………………………………………………………………………………………..............

Have you already registered with Herefordshire Carers Support or would you like us to do so for you? (www.**herefordshirecarerssupport**.org)

Already registered

Yes please register me

No thank you not at the moment

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a carer?** Yes/No

If yes could we have their name, address and relationship to you? ……………………………….

………………………………………………………………………………………………………………………………………..

Are they a patient here do you know? Yes/No/don’t know

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your next of kin? ............................................................................................................

What is their relationship to you? .............................................................................................

**-----------------------------------------------------------------------------------**

* If you are due a vaccination, check-up or smear please book at reception.
* Patients on long term medication will receive a letter asking them to book with the clinician relevant to that condition.
* If you wish please book a 10 minute “new patient check” with one of the Health Care Assistants
* If you would like details of online booking of appointments, ordering prescriptions or viewing your medical records please tick and it will be sent out to you
* Do you have any communication or information needs relating to a disability, impairment or sensory loss? YES/NO
* If yes we will communicate with you further about your requirements.

**Ethnic Origin**

Please tell us about your ethnic origin because it might help us with the early identification of conditions and illnesses that are more common in certain communities. Please tick relevant description.

A

White

 British

 Irish

 Other (please write)

B

Mixed

 White & Black Caribbean

 White & Black African

 White & Asian

 Other mixed background (please write)

C

Asian or British Asian

 Indian

 Pakistani

 Bangladeshi

 Other (please write)

D

Black or Black British

 Caribbean

 African

 White & Asian

E

Chinese or other Ethnic Group

 Chinese

 Other (please write)

**PATIENT CARE TEXT MESSAGING: CONSENT FORM**

**(Cantilupe & Hampton Dene Surgery)**

**Declaration:**

I consent to Cantilupe Surgery (& Hampton Dene Surgery) contacting me by text message for the purposes of patient care. This may include: automatic appointment reminders and clinic dates.

* I acknowledge that receiving information by text is an additional service and that it may not take place on every occasion.
* I acknowledge that the surgery does not offer a reply facility to enable patients to respond to texts directly.
* I can cancel the text message facility at any time.
* I have checked that the mobile number currently held on my record is correct.

Cantilupe & Hampton Dene surgeries will only use texts to enhance communication with patients and their use will be kept to a minimum.

Text messages are generated using a secure facility, however I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. The practice will not transmit any information which would enable an individual to be identified.

**I agree to advise the practice if my mobile number changes or if it is no longer in my possession. Cantilupe & Hampton Dene surgeries cannot be held responsible if incorrect contact numbers are provided.**

Patient Name……………………………………………….. Date of Birth ……………………………………………….

Signature …………………………………………………………………….. Date……………………………………………….

Cantilupe & Hampton Dene Surgeries do not share mobile phone contacts with any external organisations.

**For full details of our privacy policy please see our website cantilupe.com**