Whiteparish Surgery

Welcome to our Practice

Thank you for registering with our Practice. We very much hope that the services and facilities we are able to offer will help towards a healthy future for you. Providing medical services is a two-way association, and as part of your registration we require you to complete the questions below and offer you a new patient assessment which will provide a good basis for our continuing medical care.

This assessment is carried out by our Health Care Assistant, Julie Roberts, and we would be grateful if you could make an appointment for this to be done. Please remember to bring a sample of urine with you when you attend. The new patient assessment, which is for all patients over 5 years of age, is a good way of starting out properly together. We would be happy for you to have a review every three years if we do not see you for any other reason, this being in accordance with Government guidelines. Under 5 year olds will be involved in our Paediatric Scheme.

We can only be helpful if you let us know what you want. Please read our Practice Brochure or visit our website **www.whiteparishsurgery.co.uk** and feel free to ask any questions of our practice team.

Please complete the form below

………......................

I would / would not like a health check (please delete as appropriate)

First Name: ....

Surname: ....

D.O.B: ……………….............

Daytime tel. no: ………………………..

Mobile tel. No: ………………………..

Do you give permission for us to contact you via SMS messaging? Yes / No

Sex: Male / Female

Ethnic origin (please tick):

☐**White, British**	☐**Indian**
☐**White, other**	☐**Chinese**
☐**Black African**	☐**Black Caribbean**
☐**Pakistani**	☐**Bangladeshi**
☐**Vietnamese**	☐**Confidential**

☐**Other**……………………………………...

First speaking language ………………...
……………………………………………….

Occupation: …………………........

Height: …………..………………**cm/ft**

Weight: …………….…....... **kg/stone**

Do you smoke? Yes / No

If so how many do you smoke? ………

Have you ever smoked? Yes / No
If so when did you stop? ……………….

Are you a carer? Yes / No

If so, would you like to be referred to the Carers Support scheme? Yes / No

Contact details for your Next of Kin

Name: ………….……………….........

Tel. No: ………….……………….........

Do you have any allergies Yes / No
If so, what are they?………………………

…………………………………………………

…………………………………………………

If you are 16 years old or over, please complete the alcohol consumption questionnaire:

Questions	Scoring system					Your score
	0	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year	
Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	No		Yes but not in the last year		Yes during the last year	

Do you suffer or have you suffered from any of the following? (Please circle)

* Coronary heart disease * Hypertension * Chronic Obstructive Pulmonary disease
* Diabetes Mellitus * Epilepsy * Hypothyroidism
* Asthma * Cancer * A mental health problem e.g. depression
* Renal failure *Psoriasis * Parkinsons disease

Have you ever had any of the following? (Please circle)

* Heart attack * Stroke * Epileptic fit

What medication do you take? (Please specify). ………………………………………………...

………………………………………………………………………...

Patient’s signature: ………………………………………Date:……………………………………