New Patient Questionnaire

(age 16 years and over)

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

Mobile✆ : ..... What is your first language? .....

Home☎: ..... Email💻: .....

Work☎: .....

Please ✓ as appropriate:-

- ☐ I am over 16 years and would like a **SystmOne Online Account** *(to book appointments, request repeat medication, view test results etc)*. Please note that we must have an email address for this service to commence so we can email your login details to you.

- ☐ I am happy to receive text reminders from St Austell Healthcare

New Patient Check

As a new patient to St Austell Healthcare, we offer a New Patient Check with a Healthcare Assistant (HCA) who will check your weight, height, blood pressure, medical history and carry out any blood tests as necessary.

Please ✓ as appropriate:-

- ☐ I am happy with my current state of health and do not wish to take up this offer. *or*
- ☐ I will make an appointment for a New Patient Check with a HCA. *(Please bring a sample of urine.)*

Smoking Status *please tick✓*

Smoker ☐

Never smoked tobacco ☐

Ex-Smoker ☐

Height & Weight

What is your height? .....

What is your weight? .....

If you are a smoker, would you like advice on giving up smoking? Yes ☐ No ☐

Next of Kin

Please give name, address and telephone number of your next of kin:

Name:..... Tel: ..... Relationship to you:.....

Address:.....

Carers

Do you have a relative, friend or neighbour who looks after you without payment? Yes ☐ No ☐

If yes, please give name and contact details: .....

Do you look after a sick, disabled or frail relative, friend or neighbour without payment? Yes ☐ No ☐

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

Health Conditions – Do you or have you had any of the following conditions? (Please ✓ boxes that apply)

Asthma	☐	Heart Disease	☐	Cancer	☐
COPD	☐	Stroke	☐	Learning Disability	☐
High Blood Pressure Severe	☐	Epilepsy	☐		
Diabetes	☐	Dementia	☐		

Allergies
Do you have any allergies? .....

Medication
Are you on any repeat medications?.....
(Please attach a re-order form or packet if available)

Pharmacy
We are an electronic prescribing practice; this means that we are able to send your prescriptions direct to your chosen pharmacy without printing. Your medicines will be sent to the pharmacy within 3 working days of submitting your request. If you would like your prescriptions to go in this manner please nominate your preferred pharmacy. If you are new to the area please ask a member of the reception team who will be able to advise you of your nearest pharmacy.

Pharmacy name:..... Location:.....

Alcohol Intake Questionnaire
For the following questions please ✓ the answer which best applies.

Questions	Scoring System 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 when you are drinking?	1-2	3-4	5-6	7-8	10+
On a single occasion in the last year, how often do you have: **Female - 6 or more units?** **Male - 8 or more units?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Ethnic Origin &Nationality
This questionnaire follows the recommendations of the Equality and Human Rights Commission Act.

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A White
☐ British or Mixed British
☐ Irish
☐ Other white background, please specify:

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B Mixed Background
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other mixed background, please specify:

.....

C Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Other Asian Background, please specify:

.....

D Black or Black British
☐ Caribbean
☐ African
☐ Other Black Background, please specify:

.....

E Other - Please specify:

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