Pembroke Road Surgery

New Patient Questionnaire

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

Home Phone Number………………………………… Email Address………………………………..……………………….

Next of kin …………………………………………......... Relationship ………………………… Phone No ……………………

Next of kin address………………………………..……………………………………………………………………………..

……..

Have you been registered here before? YES/NO Where did you hear about us? …………..……………………

Are you a smoker? (Please circle) YES/NO If yes, what do you smoke? (e.g. cigarettes/pipe)……………………..

How many/much do you smoke per day?........... Have you ever smoked? YES/NO If yes, when did you stop? …………

Are you on any regular medication? YES/NO
When you submit your first prescription request, we may contact you if the Doctor needs to see you before issuing.

Do you have any allergies? **Drug**: YES/NO **Non-drug**: YES/NO

COMMUNICATION WITH BY TEXT **DELETE AS APPROPRIATE,*

REGISTRATION CANNOT BE COMPLETED UNTIL BOTH QUESTIONS ARE ANSWERED:

- **I CONSENT / DECLINE TO RECEIVE RESULTS BY TEXT**
- **I CONSENT / DECLINE TO RECEIVE APPOINTMENT REMINDERS / INVITES BY TEXT**

We use the appointment text messaging service to invite patients to clinics such as flu, diabetes, asthma, and also for health promotion campaigns. If you do not wish to receive these, we will opt you out of the text reminder recall service which does include appointments.

Privacy Policy – this is available at Reception or you can download from our website www.pembrokeroadsurgery.co.uk.

Please tick box to acknowledgement ☐

We aim to provide Health Services for all people, regardless of race or language. In order to do this, we need to know more about the population we are serving. This will help us to provide the right type of healthcare services for all our patients. It will also help us provide the right number of language interpreters, for example. The personal information you give us on this form will not be shared with any other organisation, including other Government departments such as the Home Office or Inland Revenue. If you have any concerns about the use of the data, please talk to a member of staff at the practice.

What do you consider to be your ethnic origin?

What language do you usually speak? ....

- o I do not wish to complete this form

Asian or Asian British
- o Bangladeshi
- o Indian
- o Pakistani
- o Asian other (please state) …………..

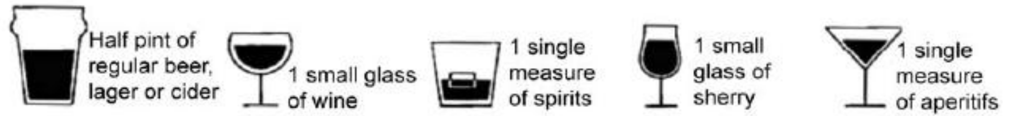
White
- o British
- o Irish
- o White other (please state) …………

Mixed Background
- o White and Asian
- o White and Black Caribbean
- o White and Black African
- o Other mixed background ……………………

Black or Black British
- o African
- o Somali
- o Caribbean
- o Black other (please state) ……………………

Other Ethnic Group
- o Chinese
- o Any Other (please state …………..…………

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing 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 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

For office use only:

ID x 2		Privacy policy		Consent completed		Initials	