

**SONNING COMMON HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE**

Full name:		Title (e.g. Mr/Mrs/Dr)	Today's Date:
Home Telephone number:		Date of birth:	
Mobile number:		Marital status:	
e-mail address:		Occupation:	
Can we contact you by:	Text: YES / NO	Email: YES / NO	
Are you a carer? YES / NO <i>(If yes, please ask for a carers form at reception)</i>		Does somebody care for you? YES / NO <i>(If yes, please advise name and contact no.)</i>	
Are you a Veteran or have you ever served in the Armed Forces? YES / NO		Do you live alone? YES / NO	
Next of Kin Name:			
Relation to patient:		Telephone:	

MEDICAL HISTORY			
Please tick the appropriate box(es) if you have been diagnosed with any of the below :			
<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Coronary Heart Disease
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Dementia	<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Other		
Height:		Weight:	

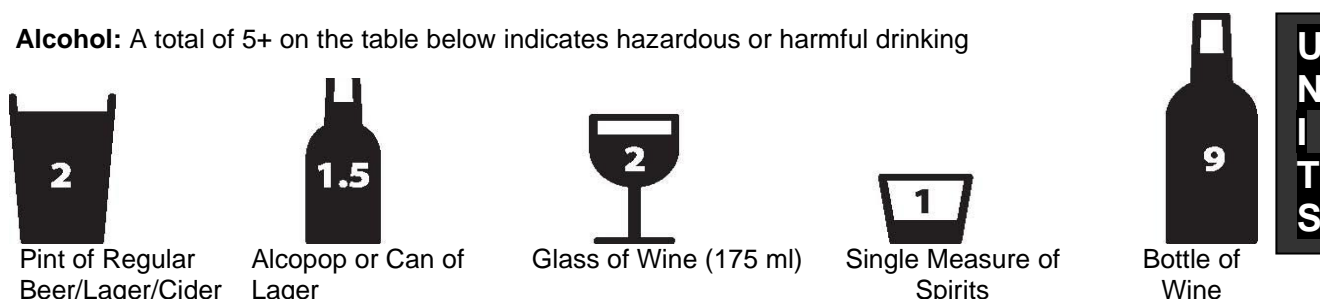
PRESCRIBED MEDICATION	
Are you on regular/repeat medication? YES / NO <i>(If yes, please bring copy of repeat slip to your first GP Appointment)</i>	
Are there any medications that upset you? YES / NO	If yes, which one(s)?
Do you have any allergies? YES / NO	If yes, which?

Non-Dispensing Patients ONLY		
Please nominate a dispensary		
<input type="checkbox"/> Day Lewis - Sonning Common	<input type="checkbox"/> Tesco - Henley	<input type="checkbox"/> Other - please provide Pharmacy name and location:
<input type="checkbox"/> Emmer Green Pharmacy - Emmer Green	<input type="checkbox"/> Boots - Henley	
<input type="checkbox"/> Caversham Pharmacy - Caversham	<input type="checkbox"/> Boots - Caversham	

FOR WOMEN	
We can provide a full range of contraceptive services at the health centre.	
Do you take the contraceptive pill? YES / NO	Have you had a cervical smear in the last 5 years? YES / NO
Do you have a coil fitted? YES / NO	

LIFESTYLE			
Smoking: <i>Please complete one of these lines</i>	a. Current Smoker		What do you smoke? CIGARETTES / PIPES / CIGARS
	b. Ex-Smoker		When did you stop smoking?
	c. Never Smoked		As you will be aware, smoking can damage your health
We would like to support you to stop smoking, for advice on how, please see information on our website under Your Health > Self Referrals. Alternatively, you can contact Smoke Free Life Oxfordshire on 0800 122 3790 or text STOPOXON to 60777			

Alcohol: A total of 5+ on the table below indicates hazardous or harmful drinking



Questions: Please answer	Scoring System					Your Score
	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	7-9	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	

If you score 5+ please make an appointment to see your GP. (Admin use only- code 38D4)

ETHNICITY – please tick							
White		Mixed/Multiple ethnicity groups		Black/African/Caribbean /Black British		Asian/Asian British	
A British		E White & Black Caribbean		I African		L Indian	
B Irish		F White & Black African		J Caribbean		M Pakistani	
C Gypsy/Irish Traveller		G White & Asian		K Other black		N Bangladeshi	
D Other white		H Other mixed				O Chinese	
Other		Q Arab		R Any other		P Other Asian	

First language spoken:	Do you need an interpreter? YES / NO
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For practice use only

Date received:	GP	Call for (GP to tick): Medication review <input type="checkbox"/> New patient review <input type="checkbox"/>
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