



**Bassett Road
Surgery**

www.bassettroadsurgery.co.uk

Dr J Henderson
Dr M Horkan
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Welcome to Bassett Road Surgery. We will request your Medical Records from your previous Doctor, but there is often a delay in them reaching us. We would, therefore, be grateful if you could complete this questionnaire to give us information on your medical history.

NEW PATIENT QUESTIONNAIRE

Personal Details: Mr/Mrs/Ms/Miss (please delete as appropriate)		Marital Status
Surname:		
Forenames:	Date of Birth:	
Address:		
.....		
.....		Post Code:
Tel (Home):	Tel (Work):	
Mobile Tel:	Occupation:	
Email (Home):	Email (Work):	
<u>PLEASE NOTE:</u> You will need to book a telephone call or an appointment with a GP to request your first repeat medication.		
<u>Medication:</u> - Please list all of your current medication:		
.....		
.....		
.....		
Have you recently been attending a Doctor for regular checks or a current problem? YES/NO (please delete as appropriate)		
If yes, please give details:		
.....		
Do you have any allergies? YES/NO (please delete as appropriate) If yes, please detail:		
.....		
.....		

Please turn over →

Past Medical History: Have you or your parents/grandparents/brothers/sisters ever suffered from: (delete as appropriate) If yes to any of the below, please indicate relationship to you:	
Hypertension	Yes/No
Heart Disease	Yes/No
Stroke	Yes/No
Diabetes	Yes/No
Cancer	Yes/No
Women: Date of Last smear test: Was the result normal?Yes/No	
Are you currently pregnant?Yes/No	
Smoking: Have you ever smoked? Yes/No If yes, how many per day?	
Do you smoke now? Yes/No Date when stopped	
Alcohol: Please complete the attached alcohol questionnaire	
Other Information: How tall are you? How much do you weigh?	
Exercise: Do you take regular exercise for 20mins or more at least twice a week, without getting out of breath? Yes/No	
Ethnic Origin: (please tick the category which best reflects your ethnic origin)	
White British <input type="checkbox"/>	White Irish <input type="checkbox"/>
White Others <input type="checkbox"/>	Indian <input type="checkbox"/>
Black Caribbean <input type="checkbox"/>	Pakistani <input type="checkbox"/>
Black African <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>
Black other, non-mixed origin <input type="checkbox"/>	Other ethnic, non-mixed <input type="checkbox"/>
Black other, mixed <input type="checkbox"/>	Ethnic group not given, patient declined <input type="checkbox"/>
Chinese <input type="checkbox"/>	Vietnamese <input type="checkbox"/>
First Language Spoken	English speaker? Yes/No
Learning Disability: Do you consider that you have a Learning Disability? Yes/No	
If you have answered 'yes' please book a routine appointment with a GP for a review of your care needs.)	
Caring for Relatives/Friends/Neighbours: Are you the principal carer of a relative, neighbour or friend? Yes/No	
If you have any particular concerns, please ask your GP for advice.	
Veterans: If you are a member of our veteran population, please tick the category which best describes your veteran status)	
Royal Marines Veteran <input type="checkbox"/>	Royal Navy Veteran <input type="checkbox"/>
Royal Air Force Veteran <input type="checkbox"/>	Army Veteran <input type="checkbox"/>
Military Veteran <input type="checkbox"/>	
Accessing Information:	
Please let us know if you have a disability, impairment or sensory loss so that we can help to make sure you can access information and get the support you need.	

Thank you for your help in completing this form.

Alcohol Questionnaire

Please circle the answer that is correct for you

Note: One unit = 1 glass of wine or ½ pint of beer or 1 measure of spirits

Questions	Answers				
How many units of alcohol do you drink per week	1-2	3-4	5-6	7-8	10+
How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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+
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 have you if female had 6 or more units and if male 8 or more units 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 failed to do what was normally expected of 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
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