

WELCOME TO THE FRIARSGATE PRACTICE

Medical notes can take some time to come through from your previous GP practice. To help us with your continuity of care, please take a few minutes to complete this questionnaire.

Surname:

Forenames:

Address:

Date of Birth:

Post Code:

E-Mail:

Home Telephone Number:

Mobile Telephone Number:

What is your marital status (please circle)? –

Single / Married / Divorced / Separated / Widowed

Are you a main carer for a relative / friend / neighbour?: Yes No
(please specify). Please ask for a Carers Information sheet.

Do you have a carer who looks after you? Yes No

Have you any sort of disability that we should be aware of? Yes No

Details of disability –

CURRENT HEALTH

How would you describe your current state of health?

Do you experience any health problems?

PAST MEDICAL HISTORY

Please list any illnesses, accidents or operations, with dates, if possible –

MEDICINES

If you are on any repeat medications, please make an appointment to see your GP before you run out. Please bring a previous repeat prescription slip with you when you attend. Please list, with dosage and frequency, any medicines or tablets you are taking and the reason for which each is being taken –

Please circle where you would like to collect your prescription from. (This will be set as a default on your records and all further prescriptions will go to your specified choice unless we are informed of any change).

Boots UK (Weeke)

Lloyds Pharmacy (St Paul's Surgery)

Boots UK (High Street)

Sainsburys In Store Pharmacy (Badger Farm)

Lloyds Pharmacy (High Street)

Springvale Pharmacy (Kings Worthy)

Lloyds Pharmacy (Silver Hill)

Tesco In Store Pharmacy (Winnall)

ALLERGIES

Are you allergic or sensitive to any medicines? Yes No

If yes, please list them –

FAMILY HISTORY

Do you or any close family members have any of the following illnesses or conditions?

- Diabetes High blood pressure Heart attack Stroke Glaucoma Cancer
 Thyroid disease Other (please specify) No relevant family history

OCCUPATION

Please list your current or, if not employed, your last occupation –

PERSONAL DETAILS AND LIFESTYLE

Height:

Weight:

<input type="checkbox"/> Never smoked tobacco		
<input type="checkbox"/> Smoker - Tobacco consumption:	Cigarettes – how many per day?	Ounces of tobacco per day?
<input type="checkbox"/> Ex-smoker:	Date stopped?	No of cigarettes per day?

Alcohol Consumption

For the following questions, please tick the answer which best applies.	1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits				
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
MEN – How often do you have EIGHT or more drinks on one occasion? WOMEN – How often do you have SIX or more drinks on more than one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often during the last year have you been unable to remember what happened the night before because you have been drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last year has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No <input type="checkbox"/>	Yes, on one occasion <input type="checkbox"/>		Yes, on more than one occasion <input type="checkbox"/>	

EXERCISE

How often do you exercise per week?
Please list the nature of your exercise, e.g., walking –

IMMUNISATIONS

Have you been immunised against any of the following and, if so, please tick and state date –

- | | | | | |
|----------------------------------|------------------------------------|--------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Typhoid | <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> BCG | <input type="checkbox"/> Influenza | <input type="checkbox"/> Other | | |

WOMEN ONLY

If appropriate, when did you last have a cervical smear?

Date: _____ Result: _____

If appropriate, what method of contraception do you use?

Have you ever had a mammogram? Yes No

If yes, when was the last one?

Date: _____ Result: _____

Please state your ethnic origin (please circle) –

British Irish Any other white background White and black Caribbean White and black African
White and Asian Any other mixed background Indian Pakistani Bangladeshi
Any other Asian background Caribbean African Any other black background Chinese
Any other ethnic group I decline to answer

First Spoken Language: _____

Text/Voice Text Messages

The practice will on occasion wish to send SMS text messages or SMS voice messages to your mobile phone or fixed land line number in order to notify you of such circumstances as changes to your booked appointment, national issues such as flu pandemics, the practice being closed due to unforeseen circumstances, etc. If you wish the practice to contact you in this manner then please tick the box:

Patient Reference Group

The Friarsgate Practice has a 'Virtual' Patient Reference Group (PRG) which is to consult with patients on a regular basis via e-mail.

The purpose of the PRG and the virtual PRG is to ensure that patients are involved in decisions on the range and quality of services provided and, over time, commissioned by the practice.

If you would like to be involved in the virtual PRG, please tick this box and ensure you have added your mobile telephone and e-mail address to the front page of this questionnaire:

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
WHICH WILL BE TREATED IN CONFIDENCE**