# SUNRAY SURGERY

Tel: (020) 8330 4056
www,sunraysurgery.nhs.net

**NEW PATIENT QUESTIONNAIRE (AGE 16+)**

Please complete the questionnaire as fully as possible Date Completed: / /

**Personal Details**

PLEASE PRINT IN CAPITALS

Title_____ First name _____

Surname: _____

Married ☐ Single☐ Widowed ☐ Other ☐

**Primary mobile contact number**: _____

Secondary contact number: _____

I consent to be contacted/text on my mobile ☐

Primary Email Address: _____

I consent to be contacted by email on this email address ☐

Language spoken: _____

Do you require an interpreter? Yes ☐ No ☐

**Next of Kin Details**

Name of Next of Kin: _____

Relationship to Patient: _____

Next of Kin mobile telephone Number: _____

**Are you a Carer?** ☐

Please tick if you are looking after someone who is ill, frail or had a long-term medical physical or learning disability.

If ticked, please ask for a Carer's Registration Form.

**Do you have a Carer?** ☐

Please tick if you have someone looking after you and your medical needs.

**Prescriptions**

You must nominate a pharmacy as scripts go electronically. Please state the name of your preferred pharmacy: _____

**Personal Medical History**

**Do you have any of the following?** Please tick:

| | | |
|---|---|---|
| ☐ Hypertension | ☐ Type 1 Diabetes | ☐ Type 2 Diabetes |
| ☐ Asthma | ☐ COPD | ☐ Cancer☐ |
| ☐ Kidney / Renal | ☐ Heart disease ( Angina, previous Heart Attack / MI ) | |
| ☐ Stroke ( CVA ) | ☐ Kidney/renal Failure | |
| ☐ Learning Difficulties | ☐ Mental Health Problems☐ Epilepsy | |

Please list any serious illnesses/Operations/accidents (and for women any pregnancy related problems) and the year they took place.

_____

**Family Medical History (Please tick)**

Has anyone in your immediate family suffered from any of the following?

- ☐ Stroke (under the age of 60)……..
- ☐ Heart Disease (Angina, Heart Attack) ……..
- ☐ High Blood Pressure ……
- ☐ Diabetes……
- ☐ Other ……

**Drugs and Medicine**

Are you allergic to any drugs or medicines? **If yes please state**----------

**Repeat Medicines**----------

Please specify all Medication taken regularly-Please supply latest repeat medication slip

| Name | Dose |
|---|---|
| | |

**Female Patients**

Date of last cervical smear:

Result: _____ Where was this done? ☐ GP Surgery ☐ Other _

Have you had a hysterectomy? ☐ When (Month/Year) _____

Are you pregnant? ☐ Estimated due date _____

**Sexual Health**

**Please tick any of the following if you would like further advice. We will be in contact to book the appointment once you are registered.**

☐ **Contraception**

E.g. Condoms, Depos, Implants or Coils

**Chlamydia Screening**

If you are between the ages of 15-24 and are sexually active, you are entitled to a free chlamydia screen. Please ask one of our receptionists for a kit. (If Chlamydia is left untreated in women, it can lead to infertility and for men; it can cause symptoms such as painful testicles).

☐ **HIV Testing**

Would you like to have an HIV blood test? (HIV is treatable and having this test does not affect any insurance premiums).

**Lifestyle Questions**

Height: _____ Weight: _____ Blood Pressure: ----------

**Smoking Status:**

- ☐ Never smoked
- ☐ Cigarettes – How many do you smoke a day?
- ☐ Pipe Smoker – How much tobacco do you smoke a day?
- ☐ Cigar Smoker – How many do you smoke a day?
- ☐ Ex-Smoker – When did you give up?

**For Help on Stop Smoking, you can call 0800 085 2903 or visit www.kick-it.org.uk**

**Alcohol Audit- C Screening Toolkit**

Do you drink alcohol? □ Yes □ No How many units per week? _

**PLEASE REFER TO PAGE FOR UNIT REFERENCE**

_____

| | 0 | 1 | 2 | 3 | 4 | Score |
|---|---|---|---|---|---|---|
| How often do you have a drink that contains Alcohol? | Never | Monthly or less | 2 – 4 times a month | 2 – 3 times week | 4 + times a week | |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 – 2 | 3 – 4 | 5 - 6 | 7 - 8 | 10+ | |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

**Alcohol Scoring**

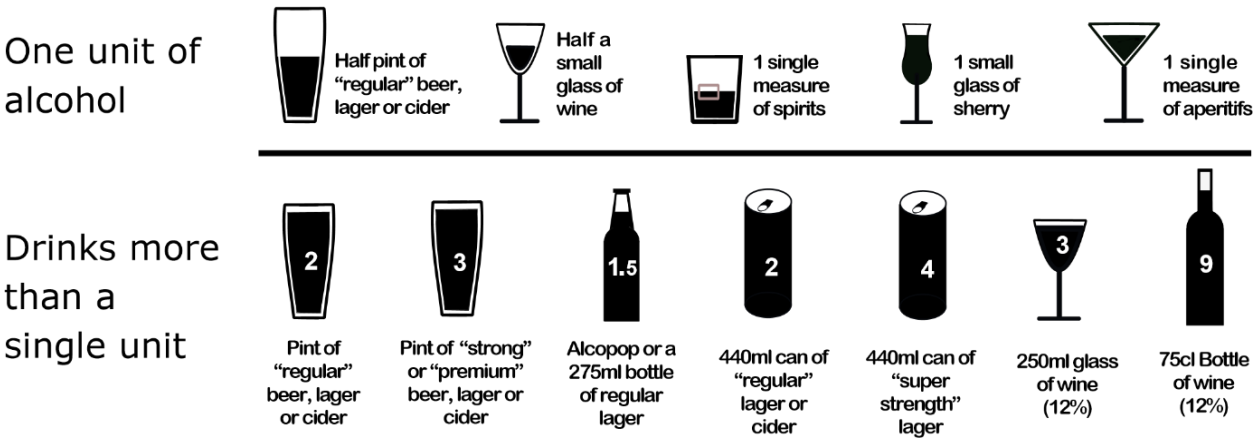
- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

**New Patient Check -** If you are in the **40-74 age group** you are entitled to have a health check if you have not had one in the last 5 years. This check is very important in detecting the early signs of some increasingly common diseases (e.g., diabetes and high blood pressure).
This will require you to have a blood test.
Would you like a check? □ **Yes** □ **No** (Practice staff Code 9mC)

**Are you serving or have served as member of British Armed Service**
□ Passport □ Driving Licence □ Other_____
Do you need help with communication? Large Print □ Braille □
Induction Loop □ British Sign Language □

**Proof of ID provided: (For Practice use only)**
□ Passport □ Driving Licence □ Other_____
**Proof of Address provided:**
□ Utility Bill □ Other _____ Initials:
_____

## Alcohol unit reference




**Ethnicity** Please tick the relevant ethnicity ✓

| | | |
|---|---|---|
| White | English / Welsh / Scottish / Irish /British | |
| | Irish | |
| | Any other White background | |
| Mixed / Multi ethnic group | White & Black Caribbean | |
| | White & Black African | |
| | White & Asian | |
| | Any other Mixed / multiple ethnic background | |
| Asian / Asian British | Indian | |
| | Pakistani | |
| | Bangladeshi | |
| | Chinese | |
| | Sri Lankan | |
| | Any other Asian background | |
| | | |
| Black / African / Caribbean | African | |
| | Caribbean | |
| | Any other Black / African / Caribbean background | |
| Other ethnic group - please specify | Any other ethnic group | |
| I Do not wish to state | | |