New Patient Questionnaire

Main Surgery
Peddars Close
Ixworth
Bury St Edmunds
Suffolk
IP31 2HD
☎ 01359 230252
Fax 01359 232586

Branch Surgery
Stanton Health Centre
12 The Chase
Stanton
Bury St Edmunds
Suffolk
IP31 2XA

Dear Patient,

First of all we would like to welcome you to our surgery and hope that you will be happy with the services we provide.

We would be grateful if you could complete the New Patient Health Questionnaire and return it to us. This information is extremely valuable to us as it is sometimes a while before we receive your medical records.

If you are on any regular medication you will need to make an appointment to see a Doctor before we can issue you any more. We have 6 Doctors here at the surgery and you are able to book an appointment up to 4 weeks in advance.

We offer a New Patient Assessment with the Healthcare Assistant or Practice Nurse for a blood pressure check. It is very important that we check your blood pressure regularly, so we would be very grateful if you could make a 10 minute appointment to have this done. We can also test your urine and make sure you are currently in good health. The nurse will be happy to answer any questions that you may have and advise where necessary.

Our appointments telephone number is 01359 230252 and press 1. Alternatively once registered with us you can register for SystmOnline, this offers you the ability to book a new appointment, cancel an appointment, view existing appointments, view your current medication and request repeat medication. Please contact reception for more details.

If you would like any more information about our Practice, please view our website on www.ixworthsurgery.co.uk alternatively if you do not have access to the internet, please ask at Reception and we will happily give you a copy of our practice leaflet

Yours sincerely

The Reception Team
For and on behalf of Ixworth Surgery

New Patient Health Questionnaire **Date completed**……

Personal Details			
Occupation		First Language	
Title:	Mr / Mrs / Miss / Ms / Other (please circle as appropriate)		
Surname:		First Names	
Date of Birth:		Sex: Male/Female (please circle as appropriate)	
Address			
If completing on behalf of a child	Are you the parent named on the birth certificate? **Yes / No**		
Telephone	Home	Work	Mobile Can we text you with appointment reminders and test results? **Yes / No**
Email Address			
Next of Kin Name		Next of Kin Telephone No	
Carer	Are **you** a Family carer		**Yes / No**
	Do you have a family carer (A family carer can include a friend, somebody not paid)		**Yes / No** Name Carer Tel No:
	Can we give your carer details about your Medical Records (if yes please sign)		**Yes / No** **Signature**

Ethnic Origin Please tick as appropriate			
White – British	☐	British Bangladeshi	☐
Irish	☐	Pakistani	☐
Other White background	☐	British Pakistani	☐
Chinese	☐	White and Black-African	☐
Indian	☐	Other mixed background	☐
British Indian	☐	African Other Black background	☐
Bangladeshi	☐	Other (please state)	☐

Health Promotion				
Height	Weight	Waist Circumference (cm)		
Smoking Status (Please Circle as Appropriate)		Never Smoked	Ex smoker	Smoker
How many cigarettes a day?		If you would like help to give up smoking we have a qualified Smoking Cessation Team. Please ask at reception for further information or an appointment		
Do you take regular exercise?		Yes / No		Hours/Minutes per week

Personal Medical History.(please circle as appropriate)					
Asthma	Chronic Obstructive Pulmonary Disease (COPD)	Diabetes	Hypertension (Raised BP)	Heart Problems	Epilepsy

Allergies		
Allergy to medication (please specify)	Allergy to animals (please specify)	Other allergies (please specify)

Medication

If you take regular medications please make an appointment to see one of the doctors, bringing with you a repeat medication slip from your previous surgery. You will need this appointment before we can issue you with any more medication

Family History (please circle as appropriate)		**Relation**
Diabetes	Yes / No	
High Blood Pressure	Yes / No	
Stroke	Yes / No	
Heart Attack	Yes / No	
Heart Disease	Yes / No	
Cancer	Yes / No If yes, type of cancer:	
Asthma	Yes / No	

Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

UNITS

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

Questions	Scoring System 0	1	2	3	4	Your Score
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: A total of 3+ indicates hazardous or harmful drinking

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SCANNING ☐ COMPUTER INPUT☐ RECALL ADDED ☐