*Please complete new patient questionnaire and ethnicity form*

# PLEASE PROVIDE 2 PROOFS OF ID – 1 CURRENT ADDRESS & PASSPORT/DRIVING LICENCE

## BURWELL SURGERY NEW PATIENT QUESTIONNAIRE

| Surname: | | First Name: |
|---|---|---|
| Mr Mrs Miss Ms Dr Professor or : | | |
| Date of Birth: | | Gender: M / F |
| Tel Nos: (home)<br>(work)<br>Email address: | | (mobile)<br>Preferred contact number:<br>Are you happy to be contacted by text? Yes/No |
| Alternative telephone contact number: (i.e. partner, next of kin): | | |
| Single / Married / Divorced / Separated / Widowed / *Civil Partnership/ Co-habiting<br>*A civil partnership is a legally recognised relationship between two people of the same sex. | | |
| Occupation: | | |
| Are you a carer? – Yes/No If so, for whom and why? | | |
| Height: | Weight: | *First language spoken: |
| ETHNIC ORIGIN:<br>White British ☐ or other, please specify ……………………………………………<br>(if not sure, please ask at reception) | | |

**Accessible Information – Making Information Clearer for Patients**
Here at Burwell Surgery, we are dedicated to the needs of all our patients, as such we would like to ensure that all information we send to you is clear and that you are able to understand it. If you feel you would like additional support, please indicate below:

| | |
|---|---|
| I would like information in large print/easy-read form or braille | YES/NO |
| I would like an interpreter service available at all appointments | YES/NO |
| I require the use of a hearing loop | YES/NO |
| My first language is not English but I am able to understand/speak English | YES/NO |

**Current Medical Problems:**

**Previous Medical Problems and Operations (please list with dates):**

**Current Medicines: (including over-the-counter medicines):**

**Allergies to Medicines/Drugs and describe reaction:**

**Any known family diagnoses, i.e, heart disease, diabetes in close relatives, parents or siblings?:**

**Do you have a nominated Pharmacy? YES/NO**
**If yes, please provide details, including address of Pharmacy:**

| ILLNESS | WHICH RELATIVE? | AGE AT ONSET |
|---|---|---|
| | | |
| | | |
| | | |

**The following two sections to be completed by patients aged 16 years and over:-**

**Smoking**

Do you smoke? YES/NO
Have you ever smoked? YES/NO
If you are an ex-smoker, when did you stop? ../../…
If you smoke, what is your daily consumption of: ……per day/per week
Please indicate whether you smoke:
Cigarettes/Cigars/Pipe(oz), e-cigarettes/other……….

## AUDIT-C ALCOHOL SCREENING QUESTIONNAIRE

**In view of recent national concerns regarding alcohol consumption, we have been asked by the Department of Health to ask all new patients the following screening questions. We may contact you to offer further assessment and advice if your answers indicate possible higher than recommended alcohol consumption.**
**Please circle your answers:**

| Question | | | | | |
|---|---|---|---|---|---|
| 1. How often to you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 or 8 | 10 or more |
| 3. How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

**Average amount of alcohol drunk per week in units:**

Beer/Cider: ………. Sherry: ………. Wine: ………. Spirits: ……….

1 unit = half pint beer/cider or 1 glass vermouth or 1 glass wine
or 1 single measure of gin/whisky/rum/vodka

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**To be completed by surgery:**

<table>
<tr><td colspan="3">Adult identification check:</td></tr>
<tr><td>Photo identity:</td><td>Passport ☐<br>Driving Licence ☐<br>Other …………………………….. ☐</td><td rowspan="2">Seen by …………………………….</td></tr>
<tr><td>Proof of address:</td><td>Type ……………………………… ☐</td></tr>
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