

Sunnyside Surgery New Patient Questionnaire

Please can you complete the following questions and then return the form to reception.

PLEASE PRINT ALL YOUR ANSWERS.

It is important that you answer all the questions below as this will help us and the Department of Health give the necessary medical support and advice to all patients.

Full Name

Address

Date of Birth

Contact telephone No. (Home).....(Mobile).....

Have you ever been registered at this practice before yes / no

If yes has thee been any change in your surname yes / no

Please tick the appropriate box to show your ethnicity

ethnicity		ethnicity	
British or mixed British		Bangladeshi or British Bangladeshi	
Irish		Other Asian background	
Other White background		Caribbean	
White and Black Caribbean		African	
White and Black African		Other Black background	
White and Asian		Chinese	
Other Mixed background		Other	
Indian or British Indian		Ethnic category not stated	
Pakistani or British Pakistani		Do not wish to disclose Ethnic Origin	

What is your main language spoken at home.....

PTO

If any of the following questions are not applicable to you please mark as N/A

Have you ever smoked cigarettes/tobacco Yes / No

If Yes how many did/do you smoke each day

Are you still smoking Yes/No

If you have stopped smoking when did you have your last cigarette.....

If you would like help to stop smoking then please book an appointment with the receptionists to see one of our 'Support to Stop Smoking Nurses'

For the following questions please place a tick in the appropriate box

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
Men how often do you have 8 or more drinks on one occasion?	0	1	2	3	4
Women how often do you have 8 or more drinks on one occasion?	0	1	2	3	4
How often in the last year have you been unable to remember what happened the night before as a result of alcohol?	0	1	2	3	4
How often during the last year have you failed to do what was normally expected of you because of drinking?	0	1	2	3	4

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No	Yes, on one occasion	Yes on more than one occasion
0	2	4

If you are not happy to complete any of the above questions please make an appointment with a Doctor or Nurse who will be happy to discuss this with you.

Thank you for taking the time to complete this questionnaire