**Diamond Medical Group**

 **New Patient Questionnaire**

*Please write clearly in black ink*

First Name …………………………………… Surname ……………………………………………

Date of Birth ………...……………………….. Email .………………………………………………

Address …………………………………………………………………………………………………

Home Tel No ………………………………………. Mobile …………………………………………..

***Online Access to appointment bookings and repeat prescriptions will be provided on registration.***

**OCCUPATION**……………………………………

**ETHNIC ORIGIN** ***(please tick one)***

□ White British

□ White Irish

□ White: any other background

□ Mixed: white & black Caribbean

□ Mixed: white & black African

□ Mixed: white & Asian

□ Mixed: any other mixed background

□ Asian or Asian British: Indian

□ Asian or Asian British: Pakistani

□ Asian or Asian British: Bangladeshi

□ Asian or Asian British: any other Asian background

□ Black or black British: Caribbean

□ Black or black British: African

□ Black or black British: any other black background

□ Chinese

□ Any other ethnic group

□ I do not wish to answer this question

*We are asking about your ethnic background so we can provide the best clinical care. There are some conditions that are more common in certain ethnic groups. Thank you for your cooperation.*

**LANGUAGE** What is your first language? ………………………………………..…….

# MEDICAL HISTORY – (Reception please inform nurse when registering patient)

* Do you suffer from any chronic or long term conditions? (please tick)

□ Diabetes □ Asthma

□ Epilepsy □ High Blood Pressure (Hypertension)

□ COPD □ Chronic Kidney Disease

□ Heart Disease □ Other (Please specify)

* Have you had any serious illness that was treated in hospital? Please give details including dates when possible. For example: heart attack, stroke, cancer, mental health problems?

…………………………………………………………………………………………………………….

## FAMILY MEDICAL HISTORY Has any family member suffered from the following?

Asthma YES/NO

Diabetes YES/NO

Epilepsy YES/NO

Stroke YES/NO

Glaucoma YES/NO

High blood pressure YES/NO

Cancer YES/NO

Heart Attack / Angina YES/NO
*(if yes, please state which relation & their age at onset)*

If yes, please give more details

……………………………………….…………………………………………………………………..

## IMMUNISATIONS AND CHILDREN’S IMMUNISATIONS

**Please bring your own immunisation records when you come for your health check.**

**Please bring your child’s health record [red book] to the first meeting with the nurse.**

# MEDICINES

Are you taking any drugs or medicines? Yes/No

*NB: You must see the Doctor before we issue you with a repeat prescription.
We reserve the right to reconsider prescribing any of your existing medication.*

Please tell us the names and dose and how often you take the medicines, please continue on a separate sheet if there are many of these. …………………………………………………………….……………………………………………………………………………………………………………………….

**All authorised orders for prescriptions will be sent electronically to a pharmacy. Please specify which pharmacy you wish to collect your medications from:**

…………………………………………………………………………………..

**TOBACCO**

|  |  |  |
| --- | --- | --- |
| Do you smoke?  | Yes/No (9R  | 137R./ XE0oh If yes, How many per day? ………………………  |
| Are you an ex-smoker? | Yes/No  |  Ub1na (yes) If yes when did you give up?………………….. |
| Do you smoke e-cigarettes?  | Yes/No  |  XaaNL How long have you been using these? ………. |

**ALCOHOL**

|  |  |
| --- | --- |
|  | Please circle one answer for each question |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per 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 |
| In a typical week how many drinks do you have? | Pints \_\_\_\_\_\_\_\_\_\_\_? Glasses of wine \_\_\_\_\_\_\_\_\_?Shorts \_\_\_\_\_\_\_\_\_\_? |

## EXERCISE

## Do you take exercise? If so, what exercise do you take? And how often? ……………………………………………………………………………

## ARE YOU A CARER?

Do you look after someone who is ill, frail or disabled? Yes/No Ub1ju (Yes)

If yes what is your relationship to them? …………………….

**DO YOU HAVE A CARER?** (Does someone look after you?)Yes/No ( 918F.(has a carer) / XaJvD (no does not have a carer)

If yes, please tell us their name, relationship to you and telephone number ………………………………………………………………….

**NEXT OF KIN** Name, address and telephone No ………………………………………………………………………………………………………………………

*We would only contact your next of kin in an emergency. We do not divulge confidential information to anyone without your permission.*

**Privacy Notice/Fair Processing Notice**: The information on this form will be processed according to data protection legislation on the legal basis of public task GDPR Article 6(1)(e) and special categories of personal data GDPR Article 9(2)h. It may be disclosed to other NHS authorities for the direct provision of healthcare or for the purpose of healthcare commissioning and planning. Please see our website for full details on how your information is stored, protected and shared. Share out allocated to record unless advised by patient.

***YOUR ALLOCATED/NAMED GP WILL BE EITHER DR WATSON, DR MATTAM OR R EVANS YOU CAN BOOK WITH ANY GP IN CONNECTION WITH YOUR CARE.***