The Pine Street Medical Practice
New Patients Questionnaire

All Questions must be answer to enable this practice to register you.

Do you smoke?
If Yes
How Many per day……Cigarettes, Cigars
How many ounces per day……Roll-ups, Pipe

If no have you ever smoked ?
How many per day……Cigarettes, Cigars
How many ounces per day……Roll-ups, Pipe

Do you drink Alcohol

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol

Never (0) Monthly or Less (1) Two to four times a month (2) Two to three times per week (3) Four or more times a Week (4) **Score**

2. How many drinks containing alcohol do you have on a typical day when you are drinking .

1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4) **Score**

3. How often do you have six or more drinks on one occasion?

Never (0) Monthly or Less (1) Two to four times a month (2) Two to three times per week (3) Four or more times a Week (4) **Score**

TOTAL SCORE

Add the number for each question to get your total score.

Do you Exercise Yes/No

If yes what exercise do you do.……

Do you or have you had any of the following. Please circle

Heart Attack, Stroke, High Blood Pressure, Angina, Diabetes, Epilepsy, TB, Glaucoma, Thalassaemia or sickle Cell.

Have any of your family had any of the following. Please circle

- Heart Attack, Stroke, High Blood Pressure, Angina, Diabetes, Epilepsy, TB, Glaucoma, Thalassaemia or sickle Cell.

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Information of Ethnic Recording

In line with other healthcare providers and all other statutory service such as local authorities etc, now collect information about ethnic group of patients. This information will help us learn more above patient's needs and then allow to plan services to meet health needs of the entire community and ensure that everyone has access to healthcare.

All information we receive will be used and treated strictest confidence.

Ethnic Group please circle which one applies to you.

White
British
Irish
Any other White background. Please state…….

Mixed
White & Black Caribbean
White & Black African
White & Asian
Any other mixed background. Please state…….

Asian or Asian British
Indian
Pakistani
Bangladeshi
Any other Asian background. Please state…….

Black or Black British
Caribbean
African
Any other Black background. Please state……..

Other ethnic group
Chinese
Any other ethnic background. Please state……

What is your first Language……..

Do you speak English. Please circle Yes No Some

Do you need an Interpreter. Please circle Yes No

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Are you on any current medication……..

Are you taking oral contraceptive……

Are you allergic to anything…… ……

When was your last Cervical Smear test……..

If so when and what was the result...……

Have you had any abnormal Cervical Smear……...

Have you has a Hysterectomy……Date…….....

Immunisation……

Are you a carer Yes/No

Are you cared for Yes/No

If yes please give there name, address and contact details.
……
……
……
……

Now answer the questions on the reverse page.

Patient Signature

Staff ID