Camberley Health Centre

Dr Fisher and Partners

NEW PATIENT QUESTIONNAIRE

A warm welcome to the practice.
Please ensure that you look on the internet at **www.camberleyhealthcentre.co.uk** to get details of the services that we offer or ask for a Practice Information Booklet.

Your answers to the following questions will allow us to administer your health records, please answer as fully as you are able

Prefix (Mr/Mrs/Dr etc)		**Date of Birth**	
First Name		**Surname**	
Tel No			
Mobile No			
Email Address			
I agree to receive messages via text and email and I will keep my contact information up to date. Delete as appropriate. If you make no selection, messages will be sent.			Yes/No

Summary Care Records I agree to the sharing of key information such as allergies and medication which are routinely shared with other NHS facilities such as hospitals in order to give me the best possible care should I fall ill or have an accident. Delete as appropriate. If you make no selection, you will be opted in.	Yes/No
New Patient Health Check Please tick here if you would like to have a New Patient Check	
Electronic Prescribing If you wish your prescriptions to be sent electronically to a pharmacy, enter its name and branch here	
Electronic Appointment Booking and Medication Requests If you wish to have an account which enables you to book and cancel appointments, order prescriptions and view your allergies and medication please ask for a leaflet.	
Are you a carer? Do you care for someone who is elderly or has special needs? If so are they	
Main Carer If you are under the age of 16, who is your main carer?	

Elderly Relative			Elderly friend/neighbour		
Disabled family member			Disabled friend/neighbour		

Ethnicity (tick one only)

A: White	British		B: Black or black British	Caribbean	
	Irish			African	
	Any other white background			Any other black background	
C: Mixed	White and black Caribbean		D: Asian or Asian British	Indian	
	White and black African			Pakistani	
	White and Asian			Bangladeshi	
	Any other mixed background			Nepalese	
E: Chinese	Chinese			Any other Asian background	
F: Other	Any other		G: Prefer not to say		

Communication

Do you have any communication issues e.g. need a BSL interpreter?	Yes/No	If yes, what are they?	

Smoking History

Never Smoked			Pipe	
Ex-Smoker			Cigarette	
If you are a smoker, would you like help and advice on giving up?				YES/NO

Alcohol Questionnaire

One unit of alcohol is:	These are more than one unit:
- Half a pint of regular beer, lager or cider - 1 small glass of wine - 1 single measure of spirits - 1 small glass of sherry - 1 single measure of aperitifs	- Pint of regular beer, lager, cider (2 units) - Pint of premium beer, lager, cider (3 units) - Alcopop or can/bottle of regular lager (1.5 units) - Can of premium lager or strong beer, 440ml (2 units) - Can of super strength lager, 440ml (4 units) - Glass of wine 175ml (2 units) - Bottle of wine (9 units)

Please circle your answers						
How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How many units of alcohol do you drink on a typical day when you are drinking?	I don't drink	1-2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

DISCLAIMER
The information entered onto this form is correct to the best of my knowledge.

I understand that the practice may use the details I provide to contact me should the need arise and that I am responsible for keeping the practice informed of any changes.

Date		**Signature**	

Please sign and date, and hand the completed form back to the receptionist