Tollcross Medical Centre

New Patient Questionnaire

The attached form must be fully completed (both sides) and returned with 2 forms of identification. (one photographic and one which states current address). Please also supply a copy of your most recent prescription request form if you are on repeat medication. Before you leave your current GP, please request one month's supply of any repeat medication you require. This will give us time to process your paperwork and add your medication to our computer system.

The next step in the registration process is an appointment with the Healthcare Assistant for a New Patient Check which reception will arrange with you. At this appointment it will be explained how the practice operates and how our appointment system works.

Many thanks

Tollcross Medical Centre
New Patient Questionnaire

To register with this Practice please complete all sections of the forms provided by writing clearly or by circling the relevant answer. Separate forms should be completed for each person in your household wishing to register.

PLEASE COMPLETE IN CAPITAL LETTERS

Title: (Mr, Mrs, Other)……..…. **Surname**: …… **Forename Name**: ……..……

Surname: ……..……..……..

First Name: ……...…….

Date of Birth: ……
(Day, month, year).

Address : ……
(House name, number, street & postcode)
…….

…….

Home Telephone Number: ……

Mobile Number: ……

Would you like to opt-in to receiving communication/results by text message **YES** **NO**

Email Address:……

Married/Single/Divorced/Separated/Cohabiting/Widowed

Ethnicity: (Please circle)

White British	**Black/Black British**	**Asian/Asian British**
White Irish	**Black Caribbean**	**Asian Indian**
White other	**Black African**	**Asian Bangladeshi**
	Black Other	**Asian Other**
British Chinese	**Mixed**	**Decline to say**
Chinese	**White & Black Caribbean**	
	White & Black African	
	White & Asian	

What is your first Language? .....

Do you require an interpreter? YES NO

If YES which Language? .....

In the case of an emergency who may we contact: .....
(Please provide name, address, contact telephone number and relationship to you)

.....

PLEASE NOW TURN OVER & COMPLETE BACK PAGE*

Please provide as much medical history as you can below

Do you have any significant health problems- if yes please give details and year of diagnosis?

Illness	Year of Diagnosis

Do you have any allergies or reactions?
(E.g. eggs, medicines, vaccinations, medical dressings or food stuff).....

Do you smoke? (please circle) **YES** **NO**

Never smoked

Current smoker **amount daily?** **How many years have you smoked?**

Ex-smoker **amount daily?** **When did you stop?**

If you would like help to stop smoking please contact any staff member of the Medical Practice for help advice or information.

Do you drink Alcohol? (please circle) **YES** **NO**

Over a weekly period how much alcohol do you drink?.....

Please circle relevant answer to questions below

Question					
How often do you have 8 (men) 6 (women) or more drinks on one occasion?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY
How often during the last year have you not been able to remember what happened when drinking the night before?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY
How often during the last year have you failed to do what was expected of you because of drinking? (e.g. work, shopping)	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	NO		YES,BUT NOT IN THE LAST YEAR		YES, DURING THE LAST YEAR

Do you exercise?

How many times a week do you exercise for 30 minutes or more? .....

If you would like any help or information on any of the above please ask at your new patient check up.
Further details about the Practice and the services we provide can be found in our Practice booklet or on our website
www.tollcrossmedicalcentre.co.uk

For Practice Staff only

Height ..... Weight ..... BMI ..... BP ..... Pulse .....

Are you a Carer? ..... Who do you care for? ..... Do you have support? .....

Practice Nurse/Healthcare Assistant signature ..... Date.....