FIRECLAY HEALTH
Your Health is Our Concern

New Patient Questionnaire for ADULTS aged 16+

Today's date: .....

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mx ☐ Other:	
Male ☐ Female ☐	Surname:
Date of Birth:	First name(s):

Home Address: Postcode:	Home Tel:
	Mobile no*: To opt out of text messages tick here ☐
	Email*: *(in block capitals)*

***Please note:** If you have provided us with an email address, we assume consent for contact by email. We assume consent to send texts to a mobile phone unless you have ticked the box to opt out. We will only text or email messages that are relevant to your ongoing healthcare, with the minimum of personal content. You are responsible for informing Fireclay Health of email address and mobile phone number changes or if your mobile phone is lost or stolen.

Ethnic Group

White British ☐ Irish ☐ Other .....
Black Caribbean ☐ African ☐ Other .....
Asian Indian ☐ Pakistani ☐ Chinese ☐ Other .....
Mixed White + Black Caribbean ☐ White + Black African ☐ Other .....

What is your first language?
If this is not English, do you require an interpreter? Yes ☐ No ☐

Communication Needs

The Practice aims to ensure that all patients can effectively communicate with us. This includes patients who have any sensory impairment or disability, and would therefore benefit from alternative methods of communication than those offered as standard. If you feel this applies to you, please ask for and complete our communication questionnaire to ensure that we can provide you with the best service and care.

I have specific communication needs Yes ☐ No ☐
If 'Yes' then complete a Communication Preference Form

Carers

Does someone look after you?
If yes, would you like them to deal with your health affairs? Yes ☐ No ☐
If yes, Please ask at reception for a Patient Consent Form

Do you look after someone? Yes ☐ No ☐
If you are a carer we will record this in your health record. Please ask at Reception for a Carers Information Pack and a form to register with us as a carer.

Women only

Are you currently pregnant? Yes ☐ No ☐ If yes, when is your due date? .....

Medical Information

Current medical conditions
Current medication *(please give strength and dosage if possible)*
Allergies to medicines or foods

Family History

Any serious illness particularly, heart disease, stroke, high blood pressure, diabetes, inherited diseases

Smoking

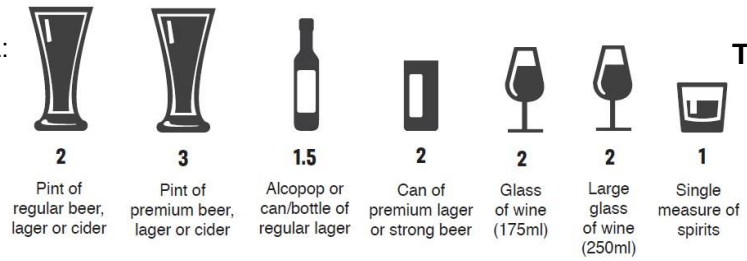
Never smoked ☐ Ex-smoker ☐ Date you gave up ..... *(month & year)*

Current smoker ☐ How many cigarettes per day? ……..

Alcohol *(circle answers & add up score)*

	Answer score					YOUR SCORE
	0	1	2	3	4	
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 units of alcohol do you drink on a typical day when you are drinking?	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	
					TOTAL	

GUIDE TO UNITS OF ALCOHOL:



☐ I decline to complete my alcohol use

Height and Weight (*you can use the height & weight scales at Lodgeside Surgery)*

What is your height? ..... m ..... cm or ..... ft ..... in	What is your weight? ..... kg or ..... st ..... lb

Blood Pressure (*if known – you can measure with machine in Reception at Lodgeside Surgery)*

What is your reading?	SYSTOLIC (top number)	DIASTOLIC (bottom number)	PULSE (beats per min)

Thank you for completing this questionnaire