FIRECLAY HEALTH
Your Health is Our Concern

New Patient Questionnaire for ADULTS aged 16+

Your Details ***print clearly*** *and as* ***fully*** *as possible to ensure we obtain correct previous medical records*	
Surname:	First name(s):
Date of Birth:	NHS no:

Contact Information

Please complete the 3rd page of this questionnaire with your contact details

Communication Needs

If you feel you have a sensory impairment or disability and would benefit from alternative methods of communication than those offered as standard, please complete our Communication Needs Form to ensure that we can provide you with the best care.

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

Ethnic Group (please tick **ONE** box)

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 ☐

Carers

Does someone look after you? Yes ☐ No ☐
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

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 use machine in Reception at Lodgeside Surgery

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

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)*

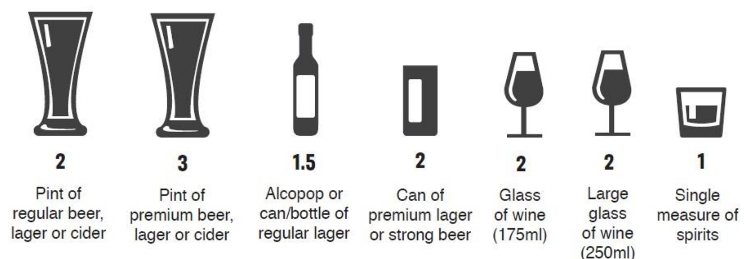
Current smoker ☐ How many cigarettes per day? ……………..

Alcohol

	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 (female) or 8 or more (male) on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL	

☐ I decline to complete my alcohol use

GUIDE TO UNITS OF ALCOHOL:



Patient consent to receive text messages & emails

Please complete this form to consent to receive messages from Fireclay Health via text (SMS) and email, and to let us know your preferred method of communication from us. Please read the following statements and complete the form below:

- We will only text or email information that is relevant to your ongoing health care e.g. appointment reminders, requests to book appointments, information following a consultation or test, prescription request/query follow-up
- Test results – please continue to phone the surgery for results as we do not text results under normal circumstances.
- We strongly recommend that, for the purposes of communication with the service, you only use a private email account / private mobile telephone (not a family or shared account or mobile phone). We also recommend that you password protect your phone, you do not display notifications on the lock screen and 'read then delete' clinical texts.
- You can opt out of receiving text messages or emails at any time by informing reception or emailing fireclayhealth@nhs.net

Patient Consent – please complete all sections & tickboxes

Mobile Number ☐

I consent to receiving text messages from Fireclay Health to this number Yes ☐ No ☐

Email Address (BLOCK CAPITALS) ☐

I consent to receiving emails from Fireclay Health to this address Yes ☐ No ☐

What is your preferred method of communication from the practice? (please tick **ONE** box)

Mobile Tel (incl texts) ☐ Email ☐ Home Tel ☐ Letter ☐ No preference ☐

I understand that it is my responsibility to inform Fireclay Health if I change my mobile phone number or email address

Name:______________________________ Date of Birth: ______________

Signed______________________________ Date ______________

Thank you for completing this questionnaire