Dear Patient

**Moorside Surgery**

370 Dudley Hill Road

Bradford

BD2 3AA

01274 643576

Welcome to Moorside Surgery. In addition to the GMS1 form we ask that

you complete our own New Patient Questionnaire.

This will enable us to provide the best care for you.

By completing this form you are consenting to SMS messages.

**New Patient Questionnaire**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | Male | Female |
| First Name(s) |  |
| Surname |  |
| DOB: | DD | MM | YY |
| Address: |  |
| Town: |  |
| Postcode: |  |
| Home Phone: |  | Preferred? |
| Mobile: |  | Preferred? |
| Work: |  | Preferred? |
| Email: |  |
| Ethnicity: | Please describe your ethnicity:  | What is your main spoken language: |
| **Next of Kin** and their relationship status to you including contact details |  |
| Are you registered Disabled?Yes/No | Details: |
| Do you have a Carer?Yes/No | Details: |
| Are you a Carer?Yes/No | Details: |

**Alcohol**

How often do you have a drink containing alcohol?  Never  Monthly or Less

 2-4 times a 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?  0  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

**Do you exercise regularly?** Yes No

**Are you a smoker?** Smoker Never smoked Ex-smoker

**Do you suffer from any of the following?** (Please circle any that apply):

Heart disease Stroke High blood pressure Diabetes Asthma Epilepsy

Mental illness Kidney disease Thyroid disease COPD Arthritis Cancer

**Please provide a brief description if you have circled any of the above**

**Have your parents/brothers/sisters ever suffered from any of the following?** (Please circle any that apply):

Heart disease Stroke High blood pressure Diabetes Cancer

**Medication:**

**Do you take regular medications?** Yes No

If yes please provide details or a repeat medication slip from your previous practice

**Do you have any allergies?** Yes No

If yes please provide details

|  |  |
| --- | --- |
| Signed (Patient) |  |
| Date |  |