ILKLEY & WHARFEDALE
MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

There can be a delay in receiving your medical records from your previous practice. In the meantime this questionnaire will provide the doctors with important information about your history and will help us to give you a better service. Please complete as fully as possible.

PATIENT DETAILS

Title:	**Mr □ Mrs □ Miss □ Ms □ Dr □ Other:**	**Surname:**	
Date of Birth:		**First Name:**	
Occupation:		**Previous Surnames:**	
Marital Status:	**Single □ Married □ Divorced □ Widowed □ Civil Partnership □**		
Home Address:		**Home Tel:**	
		Work Tel:	
		Mobile:	
		Email:	
Postcode:		**OFFICE USE ONLY:**	
NHS Number:		**Patient registered for on-line access?**	**Yes □** **No □**
Next of Kin (name):		**Relationship:**	
Next of Kin Address and Telephone Number:			
Are you (or have you been in the Army Service, Navy Service or Air Force Service? If yes please state which and when:			

ETHNIC GROUP

White	**British □**	**Irish □**	**Other □ (please specify)**
Black	**Caribbean □**	**African □**	**Other □ (please specify)**
Asian	**Indian □**	**Pakistani □**	**Chinese □** **Other □ (please specify)**
Mixed	**White and Black Caribbean □**		**White and Black African □**
	White and Asian □		**Other □ (please specify)**

What is you first language?	**Do you speak English?**

PROOF OF ID AND ADDRESS WILL BE REQUIRED AND A COPY TAKEN OF ID DETAILS

□ Birth Certificate	**□ Photo Driving Licence**	**□ Bank or Mortgage Statement**	**□ Passport**
□ Allowance Book	**□ Offer of Tenancy**	**□ Solicitors Letter**	**□ Other**

MEDICAL INFORMATION

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place					
Have you suffered from? (tick as appropriate)					
Epilepsy	**□ Yes**	**□ No**	**Blindness (Glaucoma)**	**□ Yes**	**□ No**
High Blood Pressure	**□ Yes**	**□ No**	**Diabetes**	**□ Yes**	**□ No**
Heart Attack/Stroke	**□ Yes**	**□ No**	**Depression**	**□ Yes**	**□ No**
Cancer	**□ Yes**	**□ No**	**Asthma**	**□ Yes**	**□ No**
Eczema/Hay Fever	**□ Yes**	**□ No**	**COPD**	**□ Yes**	**□ No**
Please list any medications being taken and the amount					
Medication:			**Dosage:**		
Are you allergic to any medicines and if so which?				**□ Yes**	**□ No**
If yes please provide details:					
Have you any non-medication allergies?				**□ Yes**	**□ No**
If yes please provide details:					
Have you ever refused treatment/screening of any kind and if so what?				**□ Yes**	**□ No**
If yes please provide details:					

DISABILITIES AND OTHER NEEDS (Accessible Information Standard)

It is important for us to identify and log a patient's requirements in their medical notes if they have a recorded disability.

Registered Blind	**□ Yes**	**□ No**	**Visual Impairment**	**□ Yes**	**□ No**
Registered Partially Sighted	**□ Yes**	**□ No**	**Hearing Difficulties**	**□ Yes**	**□ No**
Registered Deaf	**□ Yes**	**□ No**	**Use of Hearing Aids**	**□ Yes**	**□ No**
Registered Deaf/Blind	**□ Yes**	**□ No**	**Other:**		
Learning Disability	**□ Yes**	**□ No**			
Do you have any communication/information needs relating to a disability or sensory loss and if so what they are? For example, letters printed in size 28 plus font.					

OTHER INFORMATION

Smoking			
Are you a current smoker?		**□ Yes □ No**	
If a current smoker what do you smoke?		**Cigarettes □ Cigars □ Pipe □ E-Cigarette □**	
If a current smoker how many do you smoke a day?			
Have you ever smoked?		**□ Yes □ No**	
If you have stopped smoking please give the date			
Alcohol			
Do you drink alcohol?		**□ Yes □ No**	
If yes, how many units per week?			
MEN: How often do you have 8 or more drinks on one occasion? **WOMEN: How often do you have 6 or more drinks on one occasion?**			
How often during the last year have you been unable to remember what happened the night before because you have been drinking?			
How often during the last year have you failed to do what was normally expected of you because of drinking?			
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested cut down?			
Height and Weight			
What is your height?		**What is your weight?**	
Exercise			
Do you participate in any exercise?		**□ Yes □ No**	
If yes what exercise:		**How many hours per week?**	
Carers			
Do you have a carer?		**□ Yes □ No**	
If yes please give details:			
Are you a carer?		**□ Yes □ No**	
If yes please give details:			
Women Aged 25-60			
When was your most recent cervical smear?		**Date:**	
Please state the result if known:			

Family History:
Please state any serious illness, in particular heart attacks/angina/strokes/high cholesterol (any of these only under the date of 55 years); cancer, high blood pressure; diabetes; or any inherited disease; and which family member was/is affected

FOR PATIENTS AGED 65 AND OVER OR THOSE WITH A CHRONIC DISEASE (E.G. ASTHMA OR DIABETES)

Have you had a flu vaccination?	**Enter date or state "never":**
Have you had a pneumococcal vaccination?	**Enter date or stage "never":**

ELECTRONIC PRESCRIPTIONS (none paper)

Electronic prescribing is a computer-based electronic generation and transmission of a prescription to a pharmacy of your choice taking the place of a paper or faxed prescription. This is done to streamline the process of ordering prescriptions for both patient and the practice.

Would you like to use Electronic Prescribing?	**□ Yes □ No**
If yes please tick the pharmacy of your choice:	
Boots, Brook Street, Ilkley	□
Cohens Chemist, Burley in Wharfedale	□
Ilkley Moor Pharmacy, Cowpasture Road, Ilkley	□
Lloyds Pharmacy, Springs Lane, Ilkley	□
Rowlands, Main Street, Addingham	□

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you. All new patients are asked to make an appointment with our Practice Nurse for a Health Check. This will include a basic health questionnaire along with height, weight and blood pressure measurement. It would be appreciated if you could provide a urine sample (sample bottles are available at our reception desk).

<u>THE INFORMATION GIVEN IS IN STRICTEST CONFIDENCE AND ONLY USED BY YOUR HEALTH PROFESSIONAL</u>

Signature of Patient	Date