NEW PATIENT ASSESSMENT FORM

Dear Patient – We kindly ask that you fill out this New Patient Questionnaire. Please be aware that the questions below may indicate that you need an appointment with a Nurse or Doctor. Please complete all sections. Thank you.

Name	DOB
Postcode	Sex Male
Email I consent to email contact from the surgery □	Telephone If mobile, I consent to text reminders and messages from the surgery □
Ethnic Group (e.g. British/mixed British, Indian or British Indian, Pakistani or British Pakistani, Irish, White or Black African)	First Language

Do you have a Long-term condition? Please tick if yes.

□ Heart
□ High Blood Pressure
□ Epilepsy
□ Diabetes
□ Respiratory / lung condition
□ Cancer

Medicines

Do you take any regular medication? YES / NO

If you live in Rye which chemist would you like to use □ Boots □ Day Lewis

If you live outside of Rye we will dispense your medication

Allergies

Do you have any allergies or reactions that you are aware of? YES / NO

Please provide details – including what it is and what happens……

……

Any hospital admissions within the last 6 months? YES / NO

If yes, what for? .....

.....

Smoking status –Please tick the appropriate box.

□ Never smoked □ Current Smoker - Age Started _____ per a day_____

□ Ex-Smoker (date: ___/___/_____)

If you are a current smoker, would you like to stop smoking? YES / NO

Family History

Do you have any significant family history in your mother/ father or siblings? YES / NO Further Details: ……

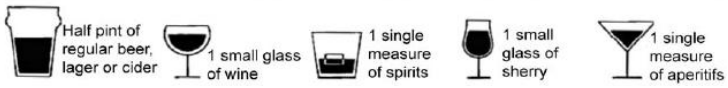
……

Sexual Health

If you are aged 19-24 would you be interested in a free Chlamydia screening pack? YES / NO

Alcohol

This is one unit of alcohol…



…and each of these are more than one unit

On average, how many units of alcohol do you have a week …….

FAST	Scoring system					Your score
	0	1	2	3	4	
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	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Carers

Do you look after someone who is ill or disabled on a regular basis Yes/No

General

Do you have any communication problems (deaf, blind, large print etc) Yes/No

Please give details ……

Do you have any mobility problems Yes/No

Please give details ……

For surgery use:	
ID provided (please state type)	
Signed and dated (by surgery staff member)	