



## Patient's details

Please complete in **BLOCK CAPITALS** and tick  as appropriate

Mr
  Mrs
  Miss
  Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

Male
  Female

Town and country of birth

Home address

Postcode

Telephone number

## Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

## If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

## If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

## If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

## If you need your doctor to dispense medicines and appliances\*

*\*Not all doctors are authorised to dispense medicines*

I live more than 1 mile in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient

Signature on behalf of patient

Date

### NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

*Signature confirming consent to organ donation*

*Date*

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

### NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

*Signature confirming consent to inclusion on the NHS Blood Donor Register*

*Date*

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: .....

## To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services  
 For the provision of contraceptive services  
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.  
 Distance in miles between my patient's home address and my main surgery is

*I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.*

Authorised Signature

Name

Date

Practice Stamp

Queensmead Road  
Loudwater  
High Wycombe  
Bucks HP10 9XA

# CHERRYMEAD SURGERY

Telephone: 01494 445150  
Fax: 01494 478636  
Office: 01494 478640

## NEW PATIENT QUESTIONNAIRE

### CONFIDENTIAL

As it may be some time before your medical records reach us, it would be a great help if you would complete one of these forms for each member of your family and return it as soon as possible.

NAME ..... DOB .....

OCCUPATION ..... Married/Single/Widowed/  
Divorced/Stable Relationship

E Mail .....

Have you seen Doctor within the last year? If yes, for what?

.....  
.....

Do you take any tablets or medicines (including the contraceptive pill) regularly?

.....  
.....

Do you have any allergies? If yes, to what and what happens to you?

.....  
.....

Do you smoke cigarettes/cigars/pipe? YES/NO If yes, how many daily? .....

What is your approximate height? ..... What is your weight? .....

When was your blood pressure last taken? .....

Have you had any vaccinations? Eg tetanus, holiday vaccinations etc If yes, can you remember approximately what and when?

.....  
.....

**FOR LADIES:** Please give the date of your last cervical smear and the result, who took it (Doctor, Family Planning Clinic, privately) and did anything need to be done?

.....  
.....

What method of contraception are you using? .....

**FOR CHILDREN:** Please list immunisations, where and by whom they were given.  
1<sup>st</sup> 2<sup>nd</sup> and 3<sup>rd</sup> triples, MMR, Rubella and Pre-school Boosters.....

.....  
.....

GP Partners:

GP Assistant

Dr Kristina King BM BCh MA MRCP DF SRH  
Dr Kirsteen Fraser MB BS BSc MRCP DCH DF SRH DR COG  
Dr Sam Elias MB ChB MRCP PGDipDerm DIM

Dr Dushan Hettiarachchi MB ChB MRCP  
Dr Wendy Payne MB BS MRCP

Have your parents or family members had problems with asthma, diabetes, epilepsy, glaucoma, heart trouble, high blood pressure, strokes or breast cancer?

.....

Have you had any of the following, please tick

	YES	NO		YES	NO
Asthma			Chest pain or Angina		
Shortness of Breath			Heart trouble		
Pneumonia			Heart Attack		
Hay Fever			High blood pressure		
Diabetes			Stroke		
Back/joint pains			Bowel trouble		
Convulsions/fits			Stomach trouble/ulcer		
Tuberculosis			Gallstones		
Problems with the womb			Jaundice		
Kidney trouble/cystitis			Cancer		
Eye problems			Nervous trouble/breakdown		
Ear trouble					

**What is your main language spoken?.....**

**WHAT IS YOUR ETHNIC GROUP?**

British or mixed British		Bangladeshi or British Bangladeshi	
Irish		Other Asian background	
Other white background		Caribbean	
White & Black Caribbean		African	
White & Black African		Other black background	
Other Mixed background		Chinese	
Indian or British Indian		Other	
Pakistani or British Pakistani		Not stated	

**PLEASE ALSO COMPLETE ALCOHOL SCREENING QUESTIONNAIRE (OVER 16)**

# PATIENT ALCOHOL QUESTIONNAIRE

## UNIT GUIDE

**1 unit is typically:**

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)



**The following drinks have more than one unit:**

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%) or a bottle of wine.



The following questions are validated as screening tools for alcohol use

### AUDIT- C Questions

	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing 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	
<b>TOTAL</b>						

A score of less than 5 indicates lower risk drinking.

**Scores of 5+ requires the following 7 questions to be completed:**

### AUDIT Questions

	Scoring system					Your score
	0	1	2	3	4	
(after completing 3 AUDIT-C questions above)						
How often during the last year have you found that you were not able to stop drinking once you had started?	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 needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after 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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
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	
<b>TOTAL</b>						