SANDY HEALTH CENTRE MEDICAL PRACTICE

D[RS.] A.K. KAPUR - A.M. PATEL - J. BAXTER – S. HIGGINS – K. NEELAGIRI

Welcome to Sandy Health Centre. Please help us by completing this questionnaire as accurately as possible. Please bring a specimen of urine in a clean container when you attend for your new patient check appointment. This information is required to help us provide you with the best possible medical care.

Name: ……. Home tel number: ……..……
Occupation: …… Height: ……..……
Date of birth: ……. Work Tel number: ……
Weight: …… Mobile tel number ……

Ethnic Origin:

White 9S1	Black Caribbean 9S2	Black African 9S3	Indian 9S6	Pakistani 9S7
Bangladeshi 9S8	Chinese 9S9	Vietnamese 9SC	Irish traveller 9SI	Other 9SJ
Other black ethnic group 9SG		Other Asian ethnic group 9SH		

Veterans: (13q3) Have you previously served in the Armed Forces? ……..…… **YES/NO**

Are you allergic or sensitive to anything (including medicines)? **YES/NO**
If yes, please state ……..…….

Smoking:
Are you a regular smoker? …… **YES/NO**
If no, have you been a regular smoker in the past? ……...……**YES/NO**
Date stopped ……..
If yes, do you smoke cigarettes ……..……...…….. **YES/NO**
cigars ……..…….…….... **YES/NO**
tobacco …….…….... **YES/NO**
How many do you smoke during an average day? …….

Alcohol:
How many units of alcohol do you drink in an average week ? ……..…….. units
(1 unit = ½ pint of beer or 1 glass of wine or 1 pub measure of spirits)

History	**Personal**	**Family(**Mother/Father/Brother etc)
Asthma		
Heart attack/Heart disease/Angina		
Cancer		
High Cholesterol		
High Blood Pressure		
Stroke		
Epilepsy		
Diabetes		

1. During the last month, have you often been bothered by feeling down, depressed or hopeless? **YES/NO**
2. During the last month, have you often been bothered by little interest or pleasure in doing things? **YES/NO**

Next of Kin:
Name of relative: …….. Relationship: ……
Contact Telephone Number: …….

Please Turn Over

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Carer Information:
Do you care for another person, whether it be a relative or friend, on a regular basis? **YES/NO**
Do you have someone that cares for you, whether it be a relative or friend, on a regular basis? **YES/NO**

Women Only:
Are you currently using any form of contraception ……..……..…… **YES/NO**
If yes, please give details ……
If using the contraceptive pill, when was your last pill check? ……...

Agreed principles between Doctor and Patient.

Please read carefully and sign below in the space provided, showing us that you have read and understood the details regarding the medical care we aim to provide for our patients.

The Patient and Doctor agree that:

1. Appointments are made for one person at a time. Please do not bring anyone else down unless they have their own appointment arranged.

2. Patients arriving late for their appointment may be asked to rearrange it.

3. Patients, who frequently do not attend for their appointments with a Doctor or Nurse without cancelling, may be removed from the list.

4. Patients, who make constant inappropriate use of any service and in particular emergency services when the surgery is closed, may be removed from the list.

5. The Doctor will always try to see all appropriate medical emergencies on the same day.

6. Visits are for patients who are too ill to attend the surgery

7. All patients on repeat medication must either use the repeat slip they are issued with or fax their request through on 01767 681600. **PLEASE NOTE THERE IS A 48-HOUR PROCESSING PERIOD FOR ALL REPEAT PRESCRIPTION REQUESTS**.

8. The practice will not tolerate violent and abusive behaviour to staff. Any patient behaving in this way will be removed from the list.

9. Please read the Practice Leaflet.

10. Any complaints, comments or suggestions should be addressed to:
    Mrs Rosena Morris, Practice Manager.

Patient's Signature …… Date……

Doctor's Signature …… Date……