**Welcome to the Market Cross Surgery**

*To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.*

Name …………………………………… …………………………………

Date of Birth: …………………Place of birth: ….…………… Marital status: ….……………

Address…….……………………………………………………………………………………

Postcode: ……………..Email address: ……………………………………

Home no: …………………………………………….Mobile: …………………………………

**Do you consent to The Market Cross Surgery texting you regarding your health and wellbeing? Yes/No**

These texts may relate to upcoming appointments, test results, forms ready for collection etc.

**It is your responsibility to update the surgery if you change your mobile phone number.**

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| **SMOKING**Do you smoke? *Yes / No* Use e- cigarette or vaporiser? *Yes/No* If *Yes*, how many:Cigarettes per day ……….. Cigars per day...……… Ounces of tobacco per day ……..How old were you when you started smoking? ………It’s always better for your health to stop smoking; we are able to refer you to our free NHS service. Can we give your details to our smoking advisor *Yes/No* **EX-SMOKERS**How old were you when you stopped smoking? ……………………..How much did you smoke per day? …………………………………..**PASSIVE SMOKING**Are you exposed to smoke at home? *Yes /No* |

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| **EXERCISE**Do you take regular exercise? *Yes / No*If yes, what sort of exercise? ………………………………………………………………….How many times per week? …………………………………………………………………..Weight (approx.)………………….. Height………………………………………………….Would you be interested in One life Healthy lifestyle service?Can we give your details to One life Suffolk? *Yes/No*  |

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| **MEDICAL HISTORY****Have you ever suffered from … please circle** Asthma Had an operationCOPD Epilepsy Depression/Anxiety High Blood pressure StrokeDiabetes (please specify) Type 1 or Type 2  Date of Diagnosis for any of above ……………………………………………….  Other problem(please specify)……………………………………………….. Heart Condition (please specify)........................................................................... | **FAMILY HISTORY****Has a member of your family ever suffered from … please circle** Asthma Had an operationCOPD EpilepsyDiabetes Depression/AnxietyStroke High Blood pressureOther chest problem(please specify)……………………………………………….. Heart Condition (please specify)...........................................................................Other (please specify)………………………………………………… |

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| **ALCOHOL**For the following questions please circle the answer which best applies 1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits**Men**: How often do you have EIGHT or more drinks on one occasion? **Women**: How often do you have SIX or more drinks on one occasion?*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* How often during the last year have you failed to do what was normally expectedof you because of drinking?  *Never Less than monthly Monthly Weekly Daily or Almost Daily* In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?  *No Yes on one occasion Yes on more than one occasion*  |

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| **CURRENT MEDICATION**  *Please include doses and attach a list if possible* **Name Dose How often do you take****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..****……………………………… …………………………. ……………………………..** |

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| Do you use or take any other medication that is not prescribed by your Doctor? *Yes/No*If yes what are these? ……………………………………………………………………Would you like any help with drug or alcohol problems? *Yes/No* |

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| **ALLERGIES**Are you allergic to any substances or foods? *Yes / No*If yes, please give details:……………………………………… |

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| **FEMALE PATIENTS**Date of most recent cervical smear?Result of most recent smear: ……………………………………………………………………Do you have an IUCD (coil) fitted? *Yes/No* When? ……………………………………..Do you have a contraceptive implant fitted? *Yes/No* When? ......................................... |

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| **REGISTERED CARERS**Are you a Registered Carer for anyone with a medical condition who would not manage without your help?*Yes / No*Who do you care for? …………………………………………………Do you have a Carer? *Yes/No* If yes could you provide us with your Carers name and contact number.………………………………………………………………………….. |

The Department of Health have asked that General Practice records ethnic origin for all patients registering after 1st April 2006.

Please tick as appropriate:

|  |  |
| --- | --- |
| White: British  Irish  Other White background  |  |
| Indian or British Indian  |  |
| Pakistani or British Pakistani  |  |
| Other Asian background  |  |
| White and Asian  |  |
| White and Black African  |  |
| White and Black Caribbean  |  |
| Chinese |  |
| Other – Please state |  |
| Ethnic group not given – patient refused |  |

**Main Spoken language ………………………………………………………………………..**

The Market Cross Surgery is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse We take seriously any threatening, abusive or violent behaviour against any of our staff or patients. Should there be any of this type of behaviour consideration will be given to take action against you.

These may include

* Seeking an Acceptable Behaviour agreement
* Excluding you from the premises
* Providing you NHS services at a different location

This approach is supported by the NHS Zero Tolerance Policy.

***Thank you for completing this questionnaire.***

Date of completion ……………………………………………………………………………………