**Ironbridge Medical Practice**

**Welcome to Ironbridge Medical Practice. As it often takes a few months for a paper copy of your Medical Records to arrive it would be helpful if you could complete this questionnaire.**

**All information provided is confidential.**

**Please answer all the questions on the questionnaire.**

**You will also be invited to make an appointment for a new patient check. This is a twenty minute appointment with the Nurse. Please ask at Reception for an appointment.**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Forenames \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide your preferred method of Communication**

Phone Text Email Letter

**Would you like information about our Online Access facility? Yes No**

**Are you a Military Veteran? Yes No**

**If yes, do you consent to us adding this data to your medical records? Yes No**

**Do you have a carer for medical reasons? Yes No**

**Are you a carer for someone? Yes No**

**If yes, who do you care for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you would like any support, please speak to our Carers’ Champion who will be able to advise you.**

**Medical History**

**Please list any major illnesses, accidents or operations with approximate dates:**

**Do you consider you have a disability? Yes No**

**If so, please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication**

**Are you taking any regular Medication? If yes, please provide details, name of medication, Dosage.**

**Allergies**

**Are you allergic to any drugs, food, etc? If so, please provide details.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History**

**Have any of your close family suffered from Heart Disease, Stroke, Diabetes, High Blood Pressure, Asthma or other serious illness?**

**If Deceased**

 **Age at Death Cause of Death**

**Father:**

**Mother:**

**Brothers:**

**Sisters:**

**Immunisations**

 **Date Date**

**Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rubella \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**German Measles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking**

**Do you smoke? Yes No**

**If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you’re an ex-smoker, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alcohol**

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2 units** | **1.5 units** | **2 units** | **1 unit** | **9 units** |
| Pint of regularBeer/Lager/Cider | Alcopop orCan of lager | Glass of wine(175ml) | Single measureOf spirits | Bottle of wine |

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring System** |  |
|  | **0** | **1** | **2** | **3** | **4** | **Your score** |
| How often do you have a drink that contains alcohol? | Never | MonthlyOr less | 2-4 timesp/ month | 2-3 timesp/ week | 4+ times p/ week |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

NB If your total score is five or over this may indicate hazardous or harmful drinking and we would encourage you to see our Practice Nurse or Doctor or discuss for fully.

In an average week, how many units of alcohol would you estimate you drink? \_\_\_\_\_\_ units

**EPS PRESCRIPTIONS**

Which local pharmacy would you like to nominate to be the recipient of your electronic prescriptions?

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**Female Patients Only**

**Are you taking an oral contraceptive? Yes No**

**If yes, which one and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you fitted with a coil? Yes No**

**If yes, what date was it fitted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had a cervical smear test? Yes No**

**If yes, date of your last screening \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any pregnancies? Yes No**

**If so, please provide dates and outcome (normal delivery/miscarriage)**

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