Gildersome Health Centre

Dr S D'Souza
Gildersome Health Centre
Finkle Lane
Gildersome Leeds
LS27 7HL
Tel: 0113 2535134 *Fax: 0113 2534899*

Practice Manager: Mrs K Prince *Practice Nurse: Ms Cheryl Conner*

NEW PATIENT HEALTH QUESTIONNAIRE

It would be helpful if you could provide us with a little background medical information. This will allow us to update your medical record as completely as possible straight away.
****Please provide proof of address where possible and/or photo ID****

PATIENT DETAILS
Surname: ……Forename(s):……..…….……..…...
Address:……..……
Date Of Birth: .....
Place of Birth……..
NHS Number (IF KNOWN)……...Occupation…….
Telephone No……
Mobile No:……....
Email Address:…….

Have you been registered with Gildersome Health Centre previously? Yes …… No…….
If Yes.why did you leave the practice? Moved out of area…….Registered at other GP surgery .....

Please tick which method of communication you prefer and also which you consent to **.Please note that this may affect the level of care we can provide if we cannot contact you easily **

SMS Consent …… Preferred…….
Mobile Consent …… Preferred…….
Landline Consent …… Preferred…….
Email Consent ……. Preferred…….

Country of Origin……
First Language …… Second Language (if appropriate) ……
Do You Need An Interpreter ? Yes / No.

Next of Kin
Name of Next of Kin…….
Relationship……..
Address (If different from Above)……
Contact Numbers……..

Smoking Status Please circle
Never Smoked / Ex-Smoker / Current Smoker (amount per day……..)

Would you like advice to stop smoking YES / NO

Dietary Infomation

Meat & Vegetables / Low Fat / Vegetarian / Vegan / Other (please state…….)

Exercise Per Week
Non / Light / Moderate / Heavy

Units of Alcohol per week ……..

Height …… **Weight** ……....

Are you a carer??...

Do You Look after Someone with Health Needs at Home Yes / No
If yes who for……..Relationship……..

Past Medical History / Operations
……..…
……....

Medications
……
……

I would like my prescriptions to be sent to a particular pharmacy
Pharmacy name & address: ……..
……..

OR (Please indicate a preference. We cannot send to pharmacy without full details)

I would like to collect my prescriptions from the surgery
……..……
……..
……..…

Allergies
……..……...
……..……

Family History (Please ring as appropriate)
Diabetes Heart Disease Asthma Cancer Stroke Hypertension

Any Other Relevant family History
……
……
……

Cervical / Pap Smear (Females only)
Date of Last Test ……
Result……... Normal / Abnormal

Communication Needs

- We want to get better at communicating with our patients .
- We want to make sure you can read and understand the information we send you .
- If you find it hard to read our letters or if you need someone to support you at appointments, Please let us know
- We want to know if you need information in braille, large print or easy read.
- We want to know if we can support you to lipread or use a hearing aid or communication tool
- Please tell a member of our administration team or call the main surgery number.

HOW WOULD YOU CLASSIFY YOUR ETHNIC ORIGIN ? (please tick as appropriate)

White
1. English / Welsh / Scottish / Northern Irish / British 2. Irish
3. Gypsy or Irish Traveller 4. Any other White background, please describe…….

Mixed / Multiple ethnic groups
5. White and Black Caribbean 6. White and Black African
7. White and Asian 8. Any other Mixed / Multiple ethnic background, please describe…….

Asian / Asian British
9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese
13. Any other Asian background, please describe……..
Black / African / Caribbean / Black British
14. African 15. Caribbean
16. Any other Black / African / Caribbean background, please describe……
Other ethnic group
17. Arab 18. Any other ethnic group, please describe……

Religion (Optional)……..

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?
……....
……
……
……..

Gildersome Health Centre

Thank you for completing this questionnaire.

The information I have given is correct to the best of my knowledge

Signed……..Patient/ Parent / Guardian

Date……..

(If you would be interested in joining our Patient participation group please ask at reception for details.)

Dear new patient, if you are over 16 (or under 16 but drink alcohol) then please complete this questionnaire in order for us to complete your health assessment. Thank you.

Scoring System

Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

If you have **scored 5 or more,** please arrange an appointment with the Practice Nurse to discuss and complete a more detailed questionnaire.

This is one unit

Half pint of regular beer ,lager or cider,1 very small glass of wine(9%), 1 single measure of spirits,1 small glass of sherry, 1 single measure of aperitifs

Signed…….

Date……..

**Please Note : Your allocated GP is Dr D'Souza ,you can see any GP in the surgery where possible **