YORK MEDICAL GROUP

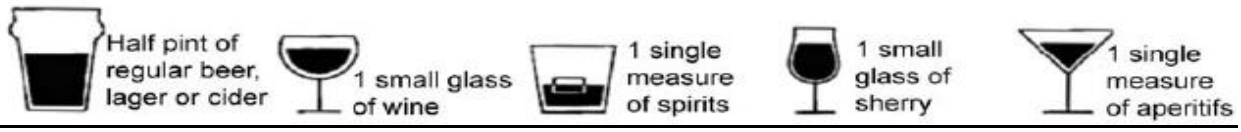
NEW PATIENT QUESTIONNAIRE
To help your doctor have full details of your medical history, we would be grateful if you would complete this form

Full Name:					
Date of Birth:					
Telephone No:			Mobile No:		
Email address:			Proof of ID Seen:		
Ethnic origin (please tick the relevant box)					
White		British	Black		Caribbean
		Irish			African
		Any other White background			Any other Black background
Mixed		White and Black Caribbean	Asian		Indian
		White and Black African			Pakistani
		Any other mixed background			Bangladesh
					Any other Asian background
Other		Chinese			
		Any other ethnic group	Not stated		Not stated/unknown
Asylum Seeker					
1st Spoken language					
Do you have any of the following medical conditions? *(Please tick as appropriate)* If yes please make an appointment with one of our Practice Nurses			Asthma COPD Diabetes Epilepsy Heart Disease		High Blood Pressure Kidney Disease Stroke Thyroid Cancer (type)
What is your height?					
What is your weight?					
Do you smoke? Yes/No			Have you ever smoked? Yes/No		
Would you like help to quit smoking?			Yes/No If yes, please contact City of York Wellbeing Service 01904 553377		
Would you like to sign up for York Medical Group On-line system to book/cancel appointments, order repeat prescriptions and view your medical record?			To sign up for the On-line system, please ask at reception or for more information go to the York Medical Group website – Appointments – Help with online services		
Do you give explicit consent for us to contact you via text messages or email?			Text - Yes/No Email – Yes/No		
Do you consent for us to share your medical records with other medical service you may be using			Yes No		
Do you use Electronic Prescribing? If yes, please inform us of your nominated pharmacy or ask Reception for more information on this service			Yes Nominated pharmacy details:		
Are you a Carer/Registered Carer? Name of person you care for: Are they registered here: Do you have a Carer? Please give details of your Carer:			Yes/No Name: Yes/No Yes/No Name:		
Do you need any special requirements when attending appointments (please circle) or please advise of any other			Deaf interpreter, Do you need longer appointments? For example if English is not your first language, or have a special condition.		

	Do you need an interpreter/signer? to accommodate learning difficulties Other .....
Would you like to take part in the York Medical Group Patient Participation Group.	Yes/No If yes, further information will be sent to you, if possible, please ensure we have your email address

Alcohol

This is one unit of alcohol…



…and each of these is more than one unit

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	

Scoring:
A total of women > 3, men > 4, indicates increasing or higher risk drinking.