

YORK MEDICAL GROUP

NEW PATIENT QUESTIONNAIRE

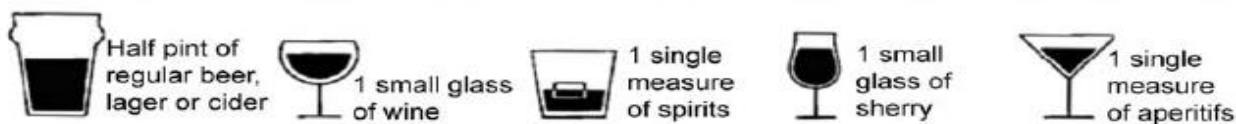
To help your doctor have full details of your medical history, we would be grateful if you would complete this form

| | | | |
|--|--------------------------|--|--------------------------------|
| Full Name: | | | |
| Date of Birth: | | | |
| Telephone No: | | Mobile No: | |
| Email address: | | Proof of ID Seen: | |
| Ethnic origin (please tick the relevant box) | | | |
| White | <input type="checkbox"/> | British | <input type="checkbox"/> |
| | <input type="checkbox"/> | Irish | <input type="checkbox"/> |
| | <input type="checkbox"/> | Any other White background | <input type="checkbox"/> |
| Mixed | <input type="checkbox"/> | White and Black Caribbean | <input type="checkbox"/> |
| | <input type="checkbox"/> | White and Black African | <input type="checkbox"/> |
| | <input type="checkbox"/> | Any other mixed background | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | Chinese | <input type="checkbox"/> |
| | <input type="checkbox"/> | Any other ethnic group | <input type="checkbox"/> |
| Asylum Seeker | <input type="checkbox"/> | Not stated | <input type="checkbox"/> |
| 1 st Spoken language | | | |
| Do you have any of the following medical conditions? <i>(Please tick as appropriate)</i> | | Asthma | High Blood Pressure |
| If yes please make an appointment with one of our Practice Nurses | | COPD | Kidney Disease |
| | | Diabetes | Stroke |
| | | Epilepsy | Thyroid |
| | | Heart Disease | 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: | |
| Have you come from the Armed Forces? | | Army | Royal Navy Royal Airforce |

| | |
|--|--|
| 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 |
| Do you have a visual or hearing impairment? | |
| Do you have an assistance dog? | Yes/No |
| 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.

