

YORK MEDICAL GROUP

NEW PATIENT QUESTIONNAIRE

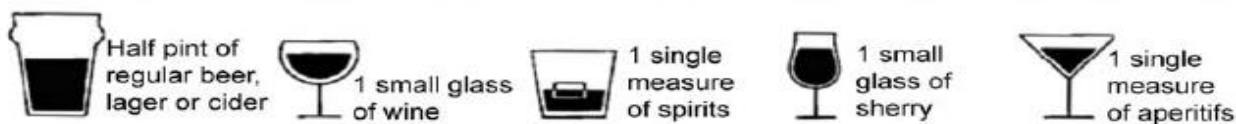
To help your doctor have full details of your medical history, we would be grateful if you would complete this form

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.

