Manor Medical Practice New Patient Questionnaire

Personal

Name _____

Date of Birth _____ Height _____ Weight _____

Age _____ Tel / Mobile Number _____

Email address _____

School Attended _____

Do you consent for your medications, allergies and additional medical information to be shared via Summary Care Record? YES NO

Do you consent to Stepping Hill Hospital A+E Department accessing your medical records if needed? YES NO

For all patients, the standard method of communication is via letter in standard font. If you have a disability or sensory loss and require an alternative method, for example, large print letters, telephone call or email format please indicate here:

_____

Next of Kin

Name _____

Relationship _____ Tel _____

Same address as yourself ☐

Ethnicity

(White) British	☐	(Black\Black British) Caribbean	☐
(White) Irish	☐	(Black\Black British) Other	☐
(White) Other Background	☐	(Mixed) White and Asian	☐
(Asian\Asian British) Bangladeshi	☐	(Mixed) White and Black African	☐
(Asian\Asian British) Indian	☐	(Mixed) White and Black Caribbean	☐
(Asian\Asian British) Pakistani	☐	(Mixed) Other	☐
(Asian\Asian British) Other	☐	(Other) Chinese	☐
(Black\Black British) African	☐	(Other) Any Other	☐

First spoken language _____