

## Manor Medical Practice New Patient Questionnaire

### Personal

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Age \_\_\_\_\_ Tel / Mobile Number \_\_\_\_\_

Email address \_\_\_\_\_

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

Are you a registered carer? 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

<input type="checkbox"/> (White) British	<input type="checkbox"/> (Black\Black British) Caribbean
<input type="checkbox"/> (White) Irish	<input type="checkbox"/> (Black\Black British) Other
<input type="checkbox"/> (White) Other Background	<input type="checkbox"/> (Mixed) White and Asian
<input type="checkbox"/> (Asian\Asian British) Bangladeshi	<input type="checkbox"/> (Mixed) White and Black African
<input type="checkbox"/> (Asian\Asian British) Indian	<input type="checkbox"/> (Mixed) White and Black Caribbean
<input type="checkbox"/> (Asian\Asian British) Pakistani	<input type="checkbox"/> (Mixed) Other
<input type="checkbox"/> (Asian\Asian British) Other	<input type="checkbox"/> (Other) Chinese
<input type="checkbox"/> (Black\Black British) African	<input type="checkbox"/> (Other) Any Other

First spoken language \_\_\_\_\_

### Smoking Status

Never smoked  Current Smoker  Current non-smoker

If applicable, are you interested in giving up smoking? YES NO

**Are you currently pregnant? YES NO**

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### Military Service

Please tick below if you are a military veteran or reservist.

- |   |  |
|---|--|
| <input type="checkbox"/> Army Veteran       | <input type="checkbox"/> Royal Air Force Veteran |
| <input type="checkbox"/> Royal Navy Veteran | <input type="checkbox"/> Royal Marines Veteran   |
| <input type="checkbox"/> Reservist          | <input type="checkbox"/> Veteran                 |

### Medication

If you are taking regular medication please attach a copy of the left page of your prescription.

### Alcohol Consumption

How often do you have 8 or more units on one occasion?

Never  Less than monthly  Monthly  Weekly  Daily

How often in the last year have you been unable to remember what happened the night before because you had been drinking?

Never  Less than monthly  Monthly  Weekly  Daily

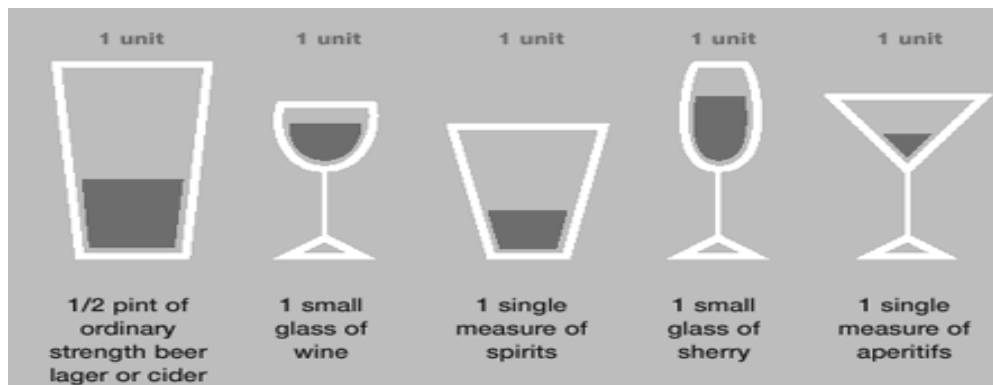
How often in the last year have you failed to do what was normally expected of you because you had been drinking?

Never  Less than monthly  Monthly  Weekly  Daily

In the last year has anyone been concerned about your drinking, or suggested you cut down?

Yes, once  Yes, more than once  No

### Guide to units



This section for practice staff to complete  
New patient health check appointment given

Date

Time

Site

Card Given