FOUNDRY
HEALTHCARE LEWES

NEW PATIENT QUESTIONNAIRE

Please return this form once completed to Reception.
To complete the registration we will need:

- **3 blood pressure readings** (please use machine in reception)
- Proof of ID and residency

OFFICE USE:
☐ 3 BP Readings and GMS1 completed
☐ Proof of ID and residency
☐ Initials of person checking and date
……

Title		**First Names**	
Date of birth		**Surname**	
Address: **Postcode**			

Home Tel No	**Mobile Tel No**	**Work Tel No**

NEXT OF KIN			
Name		**Relationship**	
Home Tel No		**Mobile No**	

Please **tick** and complete if you give us consent to contact you via the following:
(Please be aware that the contact/messages may contain confidential information about yourself).

☐ Email	☐ Text Message	☐ Leave voicemail on **Mobile phone**	☐ Leave message on **Home phone**

Please **tick** PREFERRED method of contact

☐ Email	☐ Mobile phone	☐ Home telephone

First Language is:		**Do you require a translator/use of an interpreting service?**	Yes/No
Ethnic Origin:			

White ☐ British ☐ Irish ☐ White other (please specify):	**Mixed** ☐ White and Asian ☐ White and Black African ☐ White and Black Caribbean ☐ Other mixed background (please specify):	**Other Ethnic Group** ☐ Chinese ☐ Other ethnic group (please specify):
Black or Black British ☐ African ☐ Caribbean ☐ Other Black background (please specify):	**Asian or Asian British** ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other Asian background (please specify):	☐ I do not wish to disclose my ethnic origin

Smoking	**Weight:**
☐ I have NEVER smoked ☐ I STARTED smoking in …… (year) ☐ I STOPPED smoking in …… (year) ☐ I CURRENTLY smoke …… per day	…… kg or …… stones/pounds
	Height:
	…… cm or …… feet/inches
	Blood pressure:
	…… /…… PULSE ……

Any Allergies? Please list below any medicine, substance, food, animal etc to which you have an allergy	
☐ Yes ……..	☐ None

Medication : Please list any regular medications you take		
Yes ……..		None
Nominated pharmacy: ☐	☐	☐
☐ Wyborns	☐ Boots Lewes	St Annes
Lloyds Ringmer	Bakers	

Family History **Do you have a family history of the following:**	**Yes/No**	**Date diagnosed if known**	**Family member (mother, father, sister, brother, paternal or maternal grandmother/father, aunt etc)**
CHD (Coronary Hearth Disease)			
Heart Failure (LVD)			
Hypertension			
Diabetes			
Asthma			
COPD (Chronic Obstructive Pulmonary Disease)			
Epilepsy			
Cancer			
Hypothyroidism			
Stroke or TIA (Transient Ischemic Attack)			
Mental Health			
CKD (Chronic Kidney Disease)			
Blindness/Glaucoma			
PAD (Peripheral Artery Disease)			

Do you have a Carer?	Yes	No
If yes, please give details of your Carer:	☐	☐
Are you a Carer?	Yes	No
If yes, please give details of who you care for and in what capacity:	☐	☐

Other Medical Information: Is there any medical information you feel we should know before we receive your records?
If so, please give details below

ALCOHOL QUESTIONNAIRE

How many units of Alcohol do you drink per week? ……..
1 unit of alcohol = ½ pint average strength beer/lager OR 1 small glass of wine OR 1 single measure of spirit.
3-4 units of alcohol = high strength beer/lager. 10 units of alcohol = a bottle of wine.

Questions – please circle your answers		0	1	2	3	4
1	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
3	How often do you have 6 or more units of alcohol on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	How often during the last year have you failed to do what was expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	How often during the last year have you needed an alcoholic drink in the morning to get yourself going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often during the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often during the last year have you been unable to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year
10	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the last year		Yes during the last year
	Total					

Females
If you are over the age of 50, have you attended for Breast Screening Examination ?– if not telephone 01273 664773
Date of your last cervical smear (approx.) ……..

Any concerns with your PSA – please book a GP telephone appointment to discuss this further.

Bowel Screening for ages 60-74 - You will automatically be invited to do a home test kit every 2 years. If you have not received this, please telephone 0800 707 6060

Accessible Information Standard
We want to ensure that all communication we have with our patients is clear and set out in a way that is easy to understand. If you have a disability, impairment or sensory loss and you need us to communication with you differently, **please ask reception for an ACCESSIBLE INFORMATION STANDARD FORM.**

Summary Care Record: A Summary Care Record is a national electronic record which contains information about your medication, allergies and any bad reactions you have had in the past. In an emergency, Healthcare staff can use this information to treat you more easily, especially if your GP practice is closed.

☐ **I am happy to have a Summary Care Record (you do not need to do anything).**
☐ **I would like to opt-out of having a Summary Care Record – please visit www.nhscarerecords.nhs.uk for further information and to complete the opt-out form or alternatively ask at reception.**

Patient Agreement to Foundry Healthcare

By being accepted as a patient at this surgery, the doctors and practice team make a commitment to look after you medical welfare to the best of their ability. In turn, the practice expects you, as our patient, to attend for reviews, screening, inform the practice if you cannot keep an appointment, to keep your contact details up to date and also to treat our staff with respect at all times.

SIGNED: …… DATE: ……