Lensfield Medical Practice

Adult 14 yrs + – New Patient Questionnaire

Welcome to our Practice!
We invite you to make an appointment if you wish to discuss any current issues.

Title…… **Name**……..……..……..…**Date of Birth(D/M/Y)…….……**

Address in Cambridge
……..……..……..……..……..……..……..……..……..

Telephone no: Home (in Cambridge)…… **Work**…...……..……..

Mobile……..……..…….. …….**email**……..……..……..……..……..……..

Would you like online access to book appointments and repeat medications? ……..

Next of Kin
Name……..……..…….. **Contact telephone number(s**)……..……..……..…

Relationship to you……..…..

Medication

If you are taking regular medication prescribed by your doctor or nurse please make an appointment to see the doctor or nurse before it runs out and bring a list of your medication with you.

Allergies

Are you allergic to any drugs, medicines or food? If so what and what effect did it have on you?
……..……..……..……..……..……..……..……..……..……..……..……..……..……..
……..……..……..……..……..……..
Please specify the pharmacy you plan to use from the attached list? ……..……..

Smoking Status

Smoker ☐
Ex-smoker ☐ When did you stop smoking? (dd/mm/yy) ……
Never smoked ☐

Height, Weight, Waist Circumference

If you know your height, weight and waist circumference please record them here

Height		cm	or		ft/in
Weight	Kg	or		st/lb	
Waist		cm	or		in

Carers

Are you a carer? There is assistance available for carers. If you are a carer please ask reception about this.

LENSFIELD

MEDICAL

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act

Please indicate your ethnic origin. This is not compulsory, but may help with your health care. Some health problems are more common is specific communities, and knowing your origins may help with the early identification of some of these conditions.
It is compulsory for us to have a record of your first spoken language, please specify in the section below.

Choose ONE section from A to E, and then tick ONE BOX

Name…….**Date of birth (DD/MM/YY)**……..

Please specify your first spoken language ……
Do you speak English or will you require us to book an interpreter? English/Interpreter

A White

	British
	Irish
	Other – please specify

B Mixed

	White & Black Caribbean
	White & Black African
	White & Asian
	Other – please specify

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Other – please specify

D Black or Black British

	Caribbean
	African
	White & Asian
	Other – please specify

E Chinese or any other not already listed

	Chinese

	Other – please specify

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single measure of Spirits

Bottle of Wine

ALCOHOL QUESTIONNAIRE

Forename:……..**Surname:**……. **Date of Birth:**……

	Questions	Scoring System 0	1	2	3	4	Your Score
1	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
2	How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
3	How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Now add up your score. If you score 5 of more please answer the next 7 questions. Otherwise stop here.							
4	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7	How often in 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 in the last year have you not been able 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
Now add up your total score for all 10 questions							

If you scored 0 – 7 No further action
8 – 19 Please see the nurse for some health advice.
20 + Please see the doctor for some health advice.

How long do you currently expect to be in Cambridge? ……

Are you currently studying at a language school? …….. If yes, which one? ……..

SMS COMMUNICATIONS

We are improving our service to our patients by introducing SMS and e-mail communications. We are able to offer appointment reminders, test results, advise you of changes to our services and advertise events and promotions etc. If you would like to receive such information from us please complete the following.

Name	DOB	Address
I would like to receive information via text.	Mobile telephone number	
Comments		
I accept the term and conditions	Date	Signature

CONFIDENTIALITY - TERMS AND CONDITIONS

1) We do share your data with other heath care providers only as part of your care.
2 Your IP (computer) address will be logged for security.
3) Any abuse of the system will not be tolerated.
4) LMP are all virus checked so that emails are not infected, but this cannot be guaranteed.
5.) As with any other information on the world wide web, email must not be considered secure.
6) Your email address will be stored by Lensfield Medical Practice as part of your secure confidential patient record, if you do not want us to store your address please let us know.
7.) In the future we may send you relevant information regarding your health (eg a patient newsletter, test results or appointment reminders) - we will not release your email to third parties. The internet is not secure, and the transmission of data to request medication is entirely at the patient's own risk. The practice accepts no responsibility for breaches in confidentiality resulting from patients' transmissions.