

# COMPASS HOUSE MEDICAL CENTRES

## Questionnaire for All Patients Joining The Practice

*Please complete both sides*

Title:		Marital Status:		
Surname:		Previous surname:		
Forenames:		NHS No:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date of Birth:				
Place of Birth:	(Town and County/Country)			
Current Address:				
Postcode:		Tel No(s):		
Previous Address:				
Previous GP/Surgery:				
My preferred appointments location is: <input type="checkbox"/> Brixham <input type="checkbox"/> Galmpton				
Ethnic Origin (Please Circle) <b>White</b> A British B Irish C Any other White background <b>Mixed</b> D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background <b>Asian or Asian British</b> H Indian J Pakistani K Bangladeshi L Any other Asian background <b>Black or Black British</b> M Caribbean N African P Any other Black background <b>Other ethnic categories</b> R Chinese S Any other ethnic category <b>Not stated</b> Z Not stated	Height:		Weight:	
	Smoking Status: Never <input type="checkbox"/> Current <input type="checkbox"/> Ex-smoker <input type="checkbox"/>			
	If current or ex-smoker which quantity do you/did you smoke per day? If ex-smoker when did you stop?			<1 <input type="checkbox"/> 1-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-29 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40+ <input type="checkbox"/>
	If tobacco smoker please indicate in oz per week:			
	Children Only: (under 16yrs)	Please indicate what immunisations you have had and when:-		
Female Only:	Please indicate if you: <input type="checkbox"/> have a coil fitted (please give details of type/when)  <input type="checkbox"/> contraceptive implant (please give details of type/when)			
First Language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify)	Female Only: (Age 25-64)	Please indicate the date and result of your last smear test:		
Are you are carer?: (Please give details)	Over 65s:	Please indicate if you have: <input type="checkbox"/> the annual flu jab and when last had _____ <input type="checkbox"/> had the pneumococcal immunisation and when you had it _____		
	Alcohol in units per week:	NB. Pint of regular Beer/Lager/Cider = 2 units / Alcopop or can of lager = 1.5 / 175ml wine = 2 / Single measure spirit = 1 / Bottle of wine = 9 _____		
Alcohol questions for age 16+:	Q1.	How often do you have 8 (men)/6 (women) or more drinks on one occasion?		
Q1-3 Please answer Never, Less than monthly, Monthly, Weekly, Daily or almost daily	Q2.	How often in the last year have you not been able to remember what happened when drinking the night before?		
	Q3.	How often in the last year have you failed to do what was expected of you because of drinking?		
Q4 Please answer No, Yes but not in the last year or Yes during the last year	Q4.	Has a relative/friend/doctor/health worker been concerned about your drinking or advise you to cut down?		

