The Dame Sybil Thorndike Healthcare Centre
The Thorndike & Branch Surgery

NEW PATIENT REGISTRATION/HEALTH QUESTIONAIRE

Dear Patient

Welcome to the Thorndike Surgery

To register with the Practice please complete this questionnaire as fully as possible. Please bring two forms of identification with you, i.e household bill, driving license, or passport. The information will help the doctor to make an initial assessment of your health which will help in future treatment. Please could you answer the following questions and return the form to the surgery before your first appointment so that the information can be entered on the computer as it can take sometime for your records to be transferred to the surgery.

Please book your new patient health check with reception, these appointments are pre bookable in advance. If you are in repeat mediation you will require a doctors appointment if you would like to combine doctors/nurses appointments together to save a trip we will be able to pre book this in advance which may take a little longer to organise.

If you have a **child under 5 years** of age please bring your red book with you.

Surname:	Forenames:	
Date of Birth:	Marital Status:	
Address:		
Postcode:		
Home Tel:	Mobile Tel:	Work Tel:
Email Address:		
Occupation:		
Carers details if applicable:		
Name:	Telephone:	

Ethnicity:

White British		Traveller	
White Other		Asian Chinese	
Asian Indian		Asian Other	
Asian Pakistani		Black Caribbean	
Asian Bangladeshi		Not Disclosed	
Black Other		Other	
Occupational Traveller		If ‘other’ please spec	

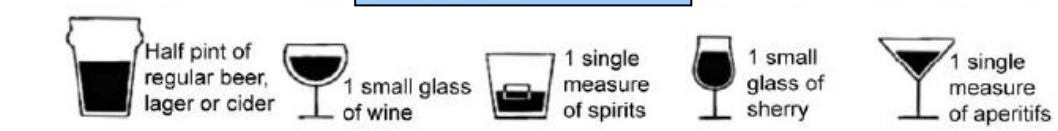
Religion:
Spoken Language:
Do you require a translator?

Please be specific on the above questions

SMOKING		
Do you smoke? Yes /No		
If yes how many?		
Cigarettes per day:	Cigars:	Tobacco: **Office Use: 137**
Codes		
How old were you when you started smoking?		**Code 8H7i**
Would you like advice on how to quit? YES/NO		**Office Use: 8CAL/8IAJ**
EX SMOKER		
How old were you when you stopped smoking?		
How much did you smoke per day?		
PASSIVE SMOKING		
Are you exposed to smoke? Yes/No Explain		

ALCOHOL **How Many Units Per Week** **TOTAL =** **Office Use: 136 codes**

This is one unit of alcohol...



...and each of these is more than one unit

Has your Cholesterol been checked in the last two years? Yes/No If yes when?

MEDICATION

Medication	**Dose**	**Why are you taking this meds**
e.g. Atenotol	50	High Blood Pressure

Family History/Medical Conditions/Allergies/Operation/ Immunisations

Name	**Date of Diagnosed**	**Operations**	**Date of Procedure**
Angina			
Asthma			
Blood Pressure			
CHD			
Diabetes			
Epilepsy			
Glaucoma			
Stroke			
Thyroid Problems			
Immunisations			
Triple/Polio/HIB			
MMR			
Tetanus			
Family History			
Is there any of the following in your family (father, mother, brother, sister) before the age of 65?			
Alzheimer/Dementia	Yes/No		
Cancer	Yes/No	Which family Members?	Site of Cancer?
Heart Disease (Heart Attacks, Angina)	Yes/No	Which family members	
Stroke	Yes/No		

Additional Information you feel may help the doctor:

Carers

Do you need / have anyone who looks after you or your daily needs as a Carer? Yes/No

If 'Yes' would you like them to deal with your health affairs here?

Do you care for anyone else? Yes / No
If 'Yes' ask the receptionist about Carers Support

Thank you for completing this questionnaire. Please do not forget to make you new health check appointment and a GP appointment if you are on medication.

Patients please sign here:

Date:

General Practice Physical Activity Questionnaire

Date……

Name……..

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week* , how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

		None	**Some but less than 1 hour**	**1 hour but less than 3 hours**	**3 hours or more**
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

Hit 'Return' to calculate PAI

Staff Check List

Practice Booklet	Yes/No	Receptionist Checking Form: NAME: SIGNATURE:	
Doctors Appointment	Date:	Date of Checking Form:	
HCA Booked	Date:	Data Entry Clerk Name:	