CHAGFORD HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE

THIS IS IN THE STRICTEST CONFIDENCE

Surname: _____Previous Surname: _____

Forenames: _____Preferred Name_____

Date of Birth: _____

Home Tel No: _____ Mobile No: _____ Work No: _____ (**Please circle preferred number**)

Consent to use your mobile phone for text messaging **Yes** **No** (please circle whichever applies)

Email address:

How would you prefer to be contacted (**Please Circle**): **SMS** **Phone** **Email**

Next of Kin Name / Relationship: _____Contact No: _____

Marital Status: _____

Allergies: _____

Please circle the preferred registered GP (Please note there is no guarantee we will be able to accommodate this.)

(please circle) **Dr Claire Hart** **Dr Matt Symonds**

Current Medication: _____
(or list from previous surgery)

PLEASE TELL US ANY OTHER IMPORTANT INFORMATION e.g. medical conditions, relevant medical family history or past medical history/operations:

Do you have help with you daily care? _____

If yes, please give details of your carer and their relationship to you: _____

Are you a Carer? _____ If yes ,to whom and relationship to you: _____

Are you an ex-serviceman/woman _____

Ethnic Origin: **White British, Mixed White, Black, Asian, other:** _____

Religion_____ Please state your first main language:_____

Height: _____ Weight: _____

Smoking Status: **Smoker / Ex Smoker / Never Smoked Tobacco (please circle whichever applies)**

If smoker would you consider appointment for smoking cessation (nurse)_____

Alcohol consumption - units per week: _____

PLEASE SEE REVERSE PAGE

Children (please circle your answer)

Are you or is your child a young carer? **YES/NO**

Does your child have a social worker or have they had support from a social worker within the last 12 months? **YES/NO**

Does your child receive additional support from any other professional agency (e.g. Speech and Language, CAMHS) ? **YES/NO**

Do you require support for your child to access the service specified above following a relocation? **YES/NO**

Adults (please circle your answer)

Do you receive support from any other professional agency (e.g. probation services, mental health teams, domestic abuse services, social services? **YES/NO**

If yes please detail which agency/s_____

Have you accessed support from any other professional agency in the last three months? **YES/NO**

If yes please detail which agency/s_____

Do you require support to access the agency specified due to relocation? **YES/NO**

Chagford Health Centre has a Patient Participation Group. If you are aged 14 and upwards and have any ideas you wish to share or are interested in joining our patient participation group please indicate by answering the questions below whether you would like to join either face to face group (attend meetings) or a virtual group (email only)

(please tick box)

Would you like to become a member of our Patient Group (attend meetings) ☐

Would you like to become a member of our Virtual Patient Group (email only) ☐