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Please state any known non-drug allergies (ie animal, elastoplast):

What if any, contraception fo						
	What if any, contraception form do you use?					
Date of last cervical smear						
Have you had a Hysterectom	y? YES / NO					
Are you currently Pregnant?	YES / NO					
immediate family in family member affe <i>Entitled Family Mei</i>	ected.	ther or Sister. Please spec	अर			
Heart attack	Heart disease	Angina				
Treat attack	Cystic Fibrosis	Epilepsy	\top			
Glaucoma						
Glaucoma Diabetes	Depression	High blood pressure				
	-	1 1 1				

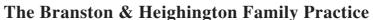
FOR HEALTH ADVICE AND INFORMATION PLEASE LOOK AT OUR WEBSITE

This form will be assessed by a Healthcare member of staff who may invite you in for an appointment to discuss any matters relating to this form however if you wish to have a New Patient Check which will involve

measuring BP, weight and height and to discuss general health matters please contact the surgery.

www.branstonsurgery.co.uk

Reviewed June 2021



Station Road Branston Lincoln LN4 1LH Telephone: 01522 793081 VAT Reg No. 879 1249 81

www.branstonsurgery.co.uk

NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS THAT ARE RELEVANT TO YOU

Welcome to our practice. It may be some time before your records reach us. The absence of these records may impair the service, which we wish to give you. It is in the interest of both yourself and your doctor that you fill in this questionnaire to the best of your knowledge.

Surname	Forename/s	DoB		
Address	Home Phone No.	Occupation -		
	Mobile No.	Religion -		
	Preferred number to contact	First Language -		
	Home / Mobile (please circle)			

Ethnic Origin (ie, White, Afrocaribbean, Asian			
Next of Kin and Contact Details:			
Have you ever been in the Armed Forces? (YES/NO) If yes, dates This includes any National Service	From:	То:	
Are you a Carer? (YES/NO) If yes, details of the person you care for:			
If you are a Carer, do you receive Carer's Allowance?:			
Does someone care for you? (YES/NO) If yes, details:			
SMS Messaging			

This is to confirm that I give consent for Branston Surgery to send text messages to my mobile phone. These texts will be to remind me of future appointments and for health matters relating to my treatment.

I am aware that if I change my mobile phone number, it is my responsibility to inform the surgery.

Email Address -

By giving the Practice my Email address I allow the Practice to contact me via email with regards to any Health Matter. The Practice has to abide by the Data Protection Act and will not release any details to a third party without your prior approval. I will inform the Practice of any change to my Email address.

Your Named GP is - Dr Mahalingam

Your named GP has overall responsibility for your care at the Practice however this does NOT mean you only have to see them. You can see other GP's at the Practice and or ANP's at the Practice.



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Please tick if you suffer from or have ever had any of the following conditions. Please indicate the date of your last review of this condition in the column below.

Asthma	Heart Trouble	
High Blood Pressure	Hayfever	
Angina	Peptic Ulcer	
T.B.	Thyroid Disease	
Bowel Trouble	Pneumonia/Bronchitis	
Epilepsy	Bladder/Kidney disease	
Diabetes	Arthritis/Joint Problems	
Stroke	Depression/Nervous Trouble	
Gynae. Problems	Cataracts	
Glaucoma	Migraine	
Any Cancers		

Are you on any repeat medication, If yes then please enclose a copy of your last prescription slip. This will help us in providing a continual supply of medication. Please be aware we are not informed of your medication needs from your previous GP.

PLEASE TELL US YOUR DESIGNATED PHARMACIST WHERE YOU WISH TO COLLECT YOUR MEDICATION

Please state any known drug allergies:	
Name of Drug/s	Reaction
Smoking Status - Please tell us if you do/do not smoke	? (please tick)
A I have never smoked	
B Lused to smoke but I do not smoke now	

If you wish to quit smoking please look at WWW.ONEYOULINCOLNSHIRE.ORG.UK or call 01522 705162

or chat to your local Pharmacist.

I do smoke

Questions	Scoring System 0 1 2 3 4			Your Score		
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	
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+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you wish to discuss your alcohol intake please ask to speak to a nurse

If you have scored more than 5 on the above scoring rating and would like some information on how to cut down on your alcohol intake please ask to see a Practice Nurse for a review, or you can contact One You Lincolnshire

Please circle your answer.

Scoring: A total of 5+ indicates hazardous or harmful drinking

Height
Weight
Hospital Care – Are you currently under Hospital Care – YES / NO If YES please give details
Do you consider yourself to have a disability – YES / NO
Detail of Impairment
Physical Impairment –
Sensory Impairment –
Learning Disability/Difficulty –
Mental Health Condition –
Other – Please state –

When you return this form please enclose a copy of your last repeat medication slip for input onto our records.

Thank you