SANDWICH MEDICAL PRACTICE

New Patient Details

Thank you for choosing to register with The Sandwich Medical Practice. The clinical and administrative team at Sandwich Medical Practice look forward to welcoming you to the practice and providing you with the best possible care. Please take time to look at our website, which contains a lot of useful information and health advice.
www.sandwichmedicalpractice.co.uk

All patients will be offered a new patient medical with the practice nurse.

Name: _____ DOB: _____

Mobile No: _____ Email: _____

Next of Kin: _____ Relationship: _____ Contact Details: _____

Ethnic Group/Religion

First Language: _____ Religion: _____

White	[ ] British	[ ] Irish	[ ] Other	If other, please specify:	
Black	[ ] Caribbean	[ ] African	[ ] Other	If other, please specify:	
Asian	[ ] Indian	[ ] Pakistani	[ ] Chinese	[ ] Other	If other, please specify:
Mixed	[ ] White + Black Caribbean [ ] White + Black African [ ] White + Asian [ ] Other		If other, please specify:		

Medication

Please attach a repeat medication slip from your previous GP or list any current medications (including the contraceptive pill)

Do you have any **Drug Allergies?** If yes, please list:

Are you registered disabled?	Yes/No	If yes, please give details
Are you a carer?	Yes/No	If yes, please give details
Do you have a carer?	Yes/No	If yes, please give details

Do you have any communication/information needs? Yes/No

If yes, please give details and explain how best we can meet your needs (i.e. information in braille, large print or easy read, or do you need a sign language interpreter.

Alcohol (16 years old and over)

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

Men: How often do you have **EIGHT** or more drinks on one occasion? Women: How often do you have **SIX** or more drinks on one occasion?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ☐ 0	Less than monthly ☐ 1	Monthly ☐ 2	Weekly ☐ 3	Daily or almost daily ☐ 4
In the last year has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No ☐ 0	Yes, on one occasion ☐ 2	Yes on more than one occasion ☐ 4		
Total for each column:					
TOTAL					

Smoking (14 years old and over)

Do you smoke? Yes/No

If no, have you ever smoked? Yes/No

If yes, how many cigarettes or ounces of tobacco do you smoke per week? ☐

Would you like advice on giving up smoking? Yes/No

Family History

Have any of your first degree relatives (parents or siblings) had heart disease, stroke, diabetes or cancer diagnosed under the age of 65? If so, please give details:

Please return this completed form to reception. Thank you.

Signature of Patient/Representative: _____ Date: _____