**LIMEFIELD SURGERY**

293 Preston New Road Blackburn BB2 6PL

[www.limefieldsurgery.co.uk](http://www.limefieldsurgery.co.uk) (E: limefield.general@nhs.net)

Tel: 01254 617630 Fax: 01254 617642

**NEW PATIENT QUESTIONNAIRE – ALL DETAILS NEED TO BE COMPLETED BEFORE REGISTRATION**

It would be helpful if you could provide us with a little background medical information. This will allow us to update your medical record as completely as possible straight away. Please complete all fields.

**PATIENT DETAILS**

|  |  |  |
| --- | --- | --- |
| **FORENAME:** | **SURNAME:** | **LANDLINE NO:** |
| **ADDRESS:** | **MOBILE NO:****Consent to contact by text** **YES/NO (Please circle)****EMAIL:****Consent to contact by EMAIL** **YES/NO (Please circle)** |
| **DATE OF BIRTH:** | **HAVE YOU BEEN A PATIENT HERE BEFORE? YES or NO (please circle)** |
| **IF UNDER 19 PLEASE GIVE:** |
| **Name of parents/guardian****Mothers Name:****Fathers Name:** |
| **Guardian:****Relationship to Child:** |
| **School/College attending:** |

**HEIGHT** (if known)………………………..…… **WEIGHT** (if known)…………….……………..

**LADIES** (if known) **Date of last Cervical Smear** ……….……….. **Date of Last Mammogram**  …………….………

**REPEAT MEDICATION**

If you are on repeat medication **please bring in the list from your previous doctor.** You **MUST** supply the details of all medication for us prior to requesting issues. Repeat prescriptions can be ordered online or by email, please visit our website at [www.limefieldsurgery.co.uk](http://www.limefieldsurgery.co.uk)

**SMOKING STATUS**

(Please tick) Never smoked……….Ex-smoker……..Current smoker………How many per day………

If you would like advice about stopping smoking please see our Nurse or visit [www.smokefree.nhs.uk](http://www.smokefree.nhs.uk). You may also visit [www.nhs.uk/change4life](http://www.nhs.uk/change4life)

**DO YOU HAVE OR ARE YOURSELF A CARER?**

Do you look after someone with health needs at home? **YES NO (please circle)**

If **YES,** who for……………………………………………………………… Please ask at reception for a carers leaflet

Do you need someone to look after your health needs at home? **YES NO (please circle)**

If **YES,** who looks after you?............................................ What relation are they?............................................

**LANGUAGE**

|  |  |
| --- | --- |
| Main language spoken: | Second language spoken: |
| Country of birth: |
| Date you entered this country (if you have not been registered with a GP before) |
| Do you need an interpreter (please circle) | YES | NO |
| Do you need alternative correspondence format such as Braille, large print, audio tape? |  |

**ETHNICITY**

**How would you classify your ethnic origin?** (please tick as appropriate)

**I would rather not answer this question: YES……..NO………**

|  |  |  |  |
| --- | --- | --- | --- |
| **White**WhiteWhite BritishWhite Irish | **Asian or Asian British**IndianPakistaniBangladeshiOther Asian | **Black**Black BritishBlack CaribbeanBlack AfricanBlack, other non-mixed origin | **Other**ChineseVietnameseNorth African Arab/IranianOther EuropeanMixedOther (please state ………………………………………………..) |

**SHARING MEDICAL RECORDS**

**Consent to contact by text…..YES/NO Consent to contact by email…..YES/NO**

**Are you happy with your medical records being shared with other health services if required:**

**YES** or **NO (please circle)**

**IF NO please ask reception for a form for you to sign to Opt Out of this service.**

**Would you like to be a member of our Patient Participation Group? YES or NO (please circle)**

**Do you wish to OPT OUT of being an Organ Donor? YES (please circle if you wish to OPT OUT Only)**

**Signed……………………………………………………………………..Dated………………………………………………………………………**

***Thank you for completing this questionnaire.***

***For Office Use Only***

***Date Registered on EMIS………………………..………. EMIS NO:………………………………………***