DELTA HEALTH CARE
NEW PATIENT QUESTIONNAIRE

Please complete as many questions as you can. The information will help your doctor provide care for you until your medical records arrive. Please complete in Black Ink.

Date: .....

Mr / Mrs / Miss / Ms / Mx Surname ..... Forenames .....

Address .....

..... Postcode.....

Previous Address .....

Home Phone Number ..... Mobile Phone Number .....

Email Address: .....

Date of Birth ..... Next of Kin: .....

Marital Status: **Single / Married / Divorced / Separated / Widow / Widower / Co-habitee** (circle)

Preferred Method of Contact: **Text** ☐ **Email** ☐ **Phone** ☐ **Post** ☐
(please tick **1** box only)

Name and Address of Previous Doctor .....

.....

Have you recently retired from the Armed Forces? **YES/NO** (please circle)

If Yes, please give date of leaving .....

Are you a permanent resident in the UK? **YES/NO** (please circle)

If NO, how long will you be staying in the UK? .....

Do you have a Deprivation of Liberty in place? **YES/NO** (please circle)

Do you have a Power of Attorney for Health and Welfare? **YES/NO** (please circle)

If YES please give details: .....

Do you have a ReSPECT form in place? **YES/NO** (please circle)

ETHNIC MONITORING

Please circle which ethnic group you feel you belong to:

White	**British / Irish / Any other white background**
Mixed	**White & Black Caribbean / White & Black African / White & Asian / Any other mixed background**
Asian or British Asian	**Indian / Pakistan / Bangladeshi / Any other Asian background**
Black or British Black	**Caribbean / African / Any other black background**
Any other Ethnic Group	**Please state** .....
Do not wish to state	

What is your first spoken language? .....

Do you speak English? **YES/NO** (please circle)

CARERS INFORMATION

Are you a Carer? **YES/NO** (please circle)

If YES, please provide brief details of who to and how you provide care .....

.....

Are you currently being cared for? **YES/NO** (please circle)

If Yes, please ask for a Carers form from reception

DISABILITY STATUS

Are you currently Registered Disabled **YES/NO** (please circle)

Do you consider yourself to have a Learning Disability? **YES/NO** (please circle)

ACCESSIBLE INFORMATION STANDARD

Do you have a disability, impairment or sensory loss and would like to receive information in a way you can easily understand? **YES/NO** (please circle)

If YES, please inform the practice as soon as possible to ensure this information is recorded. (ie Large Print, Easy to Read, via email, Braille, Sign Language)

LIFESTYLE

Do you smoke? **YES/NO** (please circle)

If YES, how many cigarettes per day .....

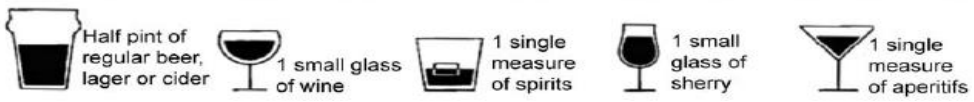
May we send you Smoking Cessation Advice? **YES/NO** (please circle)

Do you drink alcohol? **YES/NO** (please circle)

If YES, do you drink Daily / Weekly / Occasionally

How many units do you drink per week? .....

This is one unit of alcohol...



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