**Glenside Country Practice**

We would be most grateful if you could complete this questionnaire so that we can ensure the information we hold about you is correct.

|  |  |
| --- | --- |
| **Full Name** |  Date of Birth |
| **Address** |  |
| **Home Telephone Number** |  |
| **Mobile Telephone Number** |  |
| **Email Address** |  |
| **Next of Kin** |  |

We are now offering a text messaging service to all registered patients. This means you can receive appointment reminder text messages. Would you like the practice to activate this service for you? **Yes/No**

|  |  |  |
| --- | --- | --- |
| **Do you smoke** | Yes/NoEx-smoker – date stopped  | How many do you smoke a day?Cigarette/Pipe |
| **Have you received smoking cessation advice?** | Yes/No/Not Applicable | If no, would you like to?  |
| **Do you drink alcohol?** | Yes/No | How many units a week\* (approximately)? |
| \*1 pint of beer = 2 units, 125ml measure of wine = 1 |

Have you had your blood pressure taken within the last year? Yes/No

If yes, what was the result? ……………………………..…………

If no, please book an appointment to see the practice nurse.

|  |  |  |  |
| --- | --- | --- | --- |
| **Height** |  | **Weight** |  |
|  |

Do you have any of the following disabilities that you may need help with at the surgery?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mobility** |  | **Hearing** |  | **Learning Difficulty\*** |  |
| **Blindness** |  | **Language** |  | **Other\*** |  |
| \*Learning Difficulty/Other: …………………………………………………………………….……………………………..…………………………….. |

How would you describe your ethnicity? ………………………………………..……………………………..……………………………..

Do you have memory problems ? Yes/No If yes, do you wish to speak to a doctor about this ? Yes/No

Signed: ………………………………………………………………………. Date: ………………………………………………..………………