



The Cedars Surgery
wilderness medical centre

NEW PATIENT REGISTRATION / HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Surname: Forename(s):

Date of Birth: Marital status:

Address:

..... Postcode:

Home Tel: Mobile:

Email address:

Next of Kin: Tel:

Relationship:

Date of completion of this form:

Height: Weight:

PATIENT SURVEY - Are you happy to receive emails from the surgery from time to time to help us improve the service we offer? Yes No

SMOKING

- Do you smoke? Yes / No
- If Yes, how many: Cigarettes per day Cigars per day Ounces of tobacco per day
- How old were you when you started smoking?
- **Would you like help and support to give up smoking?** Yes / No

EX-SMOKERS

- How old were you when you stopped smoking?
- How much did you smoke per day?

PASSIVE SMOKING

- Are you exposed to smoke at work? Yes / No At home? Yes / No
-

Dr Joanne Donnelly, Dr Clare Nieland, Dr Amandeep Dosanjh
Associates: Dr Rajul Mehta, Dr Thieu Ngo & Dr Dushyanthi Maheswaran
8 Cookham Road, Maidenhead, Berkshire SL6 8AJ
Telephone 01628 620458



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ALCOHOL

For the following questions please circle the answer which best applies.
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

- **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 Less than monthly Monthly Weekly Daily or Almost Daily

- How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily or Almost Daily

- How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or Almost Daily

- 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 Yes on one occasion Yes on more than one occasion

EXERCISE

- Do you take regular exercise? Yes / No
 - If yes, what sort of exercise?
 - How many times per week?
-

FAMILY HISTORY

Is there any of the following in your family (father, mother, brother, sister) before age of 65?

- | | | |
|---|----------------|----------------------------|
| • Heart Disease (heart attacks, angina) | Yes / No | Which family member? |
| • Stroke? | Yes / No | Which family member? |
| • Diabetes? | Yes / No | Which family member? |
| • Cancer? | Yes / No | Which family member? |
| | Site of cancer | |
-

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MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

- Name of drug:
- Dosage:
- Name of drug:
- Dosage:
- Name of drug:
- Dosage:

ALLERGIES

- Are you allergic to any substances or foods? Yes / No

If yes, please give details:

PAST MEDICAL HISTORY

- Please give details of any hospital treatment as an in-patient in the last 12 months:
.....
.....
.....
- Please give details of any treatment for any chronic medical conditions (i.e. asthma, diabetes, heart disease):
.....
.....
.....

CARERS

- Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
- If “Yes”, would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)
- Do you care for anyone else? Yes / No
If “Yes”, ask the receptionist about Carers support.

Thank you for completing this questionnaire. Your registration will be processed within 5 working days and your previous medical records will be requested from the Health Authority.

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PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Surname: Forename(s):

Date of Birth:

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A WHITE

<input type="checkbox"/>	British	A1
<input type="checkbox"/>	Irish	A2
<input type="checkbox"/>	Any other white background please state:	A3

B MIXED

<input type="checkbox"/>	White and Black Caribbean	B1
<input type="checkbox"/>	White and Black African	B2
<input type="checkbox"/>	White and Asian	B3
<input type="checkbox"/>	Any other white background please state:	B4

C ASIAN OR ASIAN BRITISH

<input type="checkbox"/>	Indian	C1
<input type="checkbox"/>	Pakistani	C2
<input type="checkbox"/>	Bangladeshi	C3
<input type="checkbox"/>	Any other white background please state:	C4

D BLACK OR BLACK BRITISH

<input type="checkbox"/>	Caribbean	D1
<input type="checkbox"/>	African	D2
<input type="checkbox"/>	Any other white background please state:	D3

E CHINESE OR OTHER ETHNIC GROUP

<input type="checkbox"/>	Chinese	E1
<input type="checkbox"/>	Any other ethnic group, please state:	E2

F

<input type="checkbox"/>	NOT STATED	F1
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PLEASE STATE FIRST SPOKEN LANGUAGE:	
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Signing Up For Our Patient Participation Group

If you are happy for us to contact you periodically by email please leave your details below and hand this form in at reception.

Name:

Mobile No:

Email Address:

Postcode: **Date of Birth:**.....

The information below will help to make sure that we receive feedback from a representative sample of the patients registered at this practice.

Your Gender: Male Female

Your Age: Under 16 17-24

25-34 35-44

45-54 55-64

65-74 75-84

Over 84

The ethnic background with which you most closely identify is:

White British Group Irish

Mixed White & Black Caribbean White & Black African
White & Asian

Asian or Asian British Indian Pakistani Bangladeshi

Black or Black British Caribbean African

Chinese or Other Chinese Any Other

How would you describe how often you come to the practice?

Regularly Occasionally Very Rarely

Thank you

Please note that we will not respond to any medical information or questions received through the PPG.

The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.

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www.thecedarssurgery.co.uk