New Patient Information Form – Adult

Eye Health Centre

1. Background Details

Contact Details			
NHS Number	Don't know your NHS number? Visit www.nhs.uk/find-nhs-number		
Name		Gender	
Address		Date of Birth	
		Home Tel:	
		*Mobile Tel:	
		**Email:	
Previous Address			
Next of Kin	Name: Tel: Relationship:		

*Do you consent to being contacted by SMS on this number? ☐ Yes ☐ No

**Do you consent to being contacted by email at this address? ☐ Yes ☐ No

It is your responsibility to keep us updated with any changes to your contact details. If your details change once you are registered, please let a member of the Reception team know or complete the *Change of Personal Details* form on our website.

Information About You	
What is your first language?	
What is your occupation?	
Are you a carer?	☐ Yes – Informal/Unpaid Carer ☐ Yes – Occupational/Paid Carer ☐ No
Do you **have** a carer?	☐ No ☐ Yes
Do you have any communication needs?	☐ Yes ☐ No (if yes please specify below) ☐ Hearing Aid ☐ Lip Reading ☐ Large Print

2. Medical History

Medical History			
Please indicate if you have ever suffered from any of the following:			
☐ Asthma ☐ Heart Attack ☐ Heart Failure ☐ Eczema	☐ Angina ☐ COPD ☐ High Blood Pressure ☐ Stroke	☐ Depression ☐ Epilepsy ☐ Kidney Disease	☐ Diabetes ☐ Heart Disease ☐ Cancer Type:

Do you have any allergies?
Please record below:

Current Medication		
Please list your current medication, including names, doses, and how often you take them:		
Medication	**Dose**	**Frequency**

You will need to provide us your repeat medication slip from your previous practice to order a repeat prescription from us for the first time

3. Your Lifestyle

Lifestyle				
Height				
Weight				
Hours of exercise per week	☐ Less than 1	☐ 1-3	☐ 4-6	☐ 7+

Alcohol						
Audit – C Questions	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
A total score of 5+ indicates higher risk drinking. **SCORE:**					**TOTAL**	

If your total score from the previous 3 questions was 5 or higher, please complete the further questions below:

Audit Questions (if scoring 5+ in above 3 AUDIT-C questions)	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	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 from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in last year		Yes, during last year	
					TOTAL SCORE:	

Alcohol units guide:

Type of Drink	Number of units
Half a pint of regular beer, larger or cider	1
A small glass of wine	1
A single measure of spirits	1
A pint of 3.5% beer, lager or cider	2
A pint of 5% beer, lager or cider	3
A 500ml can of 4% lager or strong beer	2
A 500ml can of 8% lager	4
A medium (175ml) glass of 11% wine	2
A bottle of 12% wine	9

Smoking					
What is your smoking status?	☐ Never Smoked	☐ Ex-smoker	☐ Current Smoker		
How many cigarettes did you/do you smoke a day?	☐ Less than 1	☐ 1-9	☐ 10-19	☐ 20-39	☐ 40+

4. Further Details

Electronic Prescribing	
If you would like your prescriptions to be sent electronically to a pharmacy, please provide the details of the pharmacy you would like to use :	Pharmacy:

Patient Participation Group	
Would you like to be involved in our Patient Participation Group?	☐ Yes ☐ No

We are committed to improving the services we provide and gain valuable feedback from our patients via the Patient Participation Group.

Date: ……

Patient
Signature: ……..

Signature on
Behalf of Patient: ……..

Relationship to Patient: ……

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