Brandon Medical Practice

Elbourne Surgery, 31 High Street,
Brandon, Suffolk, IP27 0AQ
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www.brandonmedicalpractice.org.uk

Welcome to Brandon Medical Practice. Please help us by filling out as much of this new patient questionnaire as possible. It can take some time for your medical records to reach us so we would like to get as much information about you as possible. Please return these forms with photographic ID.

Name:
Date of birth:
Address: **Postcode:**
Home telephone :
Mobile number:
E-mail:

Ethnicity

I would describe my ethnic origin as: (please tick as appropriate)

White:	**Mixed:**	**Black or Black British:**	**Asian or Asian British:**	**Other ethnic Groups**
British ☐	White and black Caribbean ☐	Caribbean ☐	Indian ☐	Chinese ☐
Irish ☐	White Black African ☐	African ☐	Pakistani ☐	Any other ethnicity ☐
Any other ☐	White and Asian ☐	Any other black background ☐	Bangladeshi ☐	
	Any other mixed background ☐		Any other Asian background ☐	

First spoken language_____ Interpreter required Yes ☐No ☐

Smoking

Current smoker ☐	E-cigarette user ☐	Ex smoker ☐	Never smoked☐
Cigarettes_____ per day , Tobacco_____gms per week, Cigars_____per day			

If you are a smoker and would like help and advice to give up, we can offer support within the surgery please ask at reception for more details.

Your health

Have you got any allergies?	**If yes state below**
Drugs/Medicines?	
Any other	

Have you or any member of your immediate family ever had any of the following:

Condition	**Yourself**	**Relative (Please state which family member)**
Heart attack or Angina?		
Stroke?		
Diabetes?		
Epilepsy?		
Mental Health Condition?		
High Cholesterol?		
High Blood Pressure?		
Asthma/ COPD?		
Cancer? (type)		

Do you have a disability? Please state	

Are you a carer for a family member? Yes ☐ No ☐

Online services:
We offer our patients the ability to book appointments and request repeat prescriptions on line if you would like to access this service please read below and tick all the services you would like to access

Booking on line appointment's	☐
Requesting Repeat Prescriptions	☐

Please read and agree to the following terms and conditions

1. I agree to use the system in a responsible manner, in accordance with all the instructions given to me by the practice if not access may be withdrawn ☐
2. I agree that it is my responsibility to keep secure the user name and password that I will be given. ☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement. ☐
4. I agree that online services are provided at the discretion of the practice and may be withdrawn by the practice at any time. ☐

Signature		Date	

Your online services password will be e-mailed to you within 7 working days

We would like to contact you via text messaging or e-mail (for appointment reminders or notifications) please tick the box if you **DO NOT** want us to contact you this way ☐