

**OLD TOWN SURGERY
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 is not compulsory, but 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.

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

Name.....Date of Birth.....

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please specify

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please specify

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please specify

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	Any other black background please specify

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other background please specify

First Language Spoken

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