# New Patient Questionnaire

| **Personal Details** | **Name:** | |
|---|---|---|
| Address: | D.O.B: / / | |
| | NHS Number: | |
| | Male ☐ Female ☐ | |
| Post Code: | Marital Status: | |
| Telephone – Home | | Occupation (Last job if retired) |
| Telephone – Mobile | | |
| Telephone – Work | | |
| Email: | | **Next of Kin** |
| Reason for change of surgery | | Name: |
| | | Tel Number: |

**Personal Medical History** Do you have/have had any of the following – (***Tick if appropriate)***

| | | | | | |
|---|---|---|---|---|---|
| ANGINA | | HEART ATTACK | | ATRIAL FIBRILATION | |
| HIGH BLOOD PRESSURE | | HEART FAILURE | | DIABETES | |
| STROKE/MINI STROKE/TIA | | EPILEPSY | | KIDNEY DISEASE | |
| COPD | | ASTHMA | | THYROID PROBLEMS | |
| DEMENTIA | | DEPRESSION | | OTHER MENTAL ILLNESS | |

******************IF YOU HAVE TICKED ANY OF THE ABOVE****************

**********************PLEASE BOOK A NEW PATIENT MEDICAL***********************

| **ADULTS** | **CHILDREN** |
|---|---|
| Other illness/Injuries: | Place of birth: |
| | Type of Delivery: Normal/Forceps/Caesarean |
| Operations: | Feeding: Breast/Bottle/Mixed |
| | Problems as a baby: |
| Disabilities: | Special needs/disability: |
| Current Problems Causing Concern: | Other illness/injuries/admissions to hospital: |
| Last Tetanus: | Up to date immunisations? Yes/No/Don't know |
| **Females Only** | **Parental Responsibility** |
| Contraception: | Who has parental responsibility for this child? |
| Last Smear: | Name(s): Relationship to child: |
| Last Mammogram: | Which School/Nursery is your child attending? (<18 year) |
| Last Rubella: | |

**Current Medication:**

*(Please provide a copy of your last repeat slip if you are taking regular medications)*

**Allergies:**

**Family**

| Partners Name: | |
|---|---|
| Children (Name & Age) | |

***Do You Smoke?***

| | | | |
|---|---|---|---|
| Yes | | Pipe/Cigar/Cigarettes ***(Delete as appropriate)*** | |
| Used To | | How Many Each Day | |
| Never | | When Stopped | |

| *Do You Drink Alcohol? YES/NO* | If you have answered yes please complete the following questions | | | | | |
|---|---|---|---|---|---|---|
| **Score** | **0** | **1** | **2** | **3** | **4** | **Your Score** |
| How often do you have a drink that contains alcohol? | Never | Monthly or Less | 2-4 Times Per Month | 2-3 Times Per Week | 4+ Times Per Week | |
| How many drinks do you have on a day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ | |
| How often do you have 6 or more drinks on one occasion? | Never | Less Than Monthly | Monthly | Weekly | Daily or Almost Daily | |
| ****************IF YOU HAVE SCORED 5 OR MORE****************<br>***********************PLEASE BOOK A NEW PATIENT MEDICAL *********************** | | | | | | |

| *Do You Exercise?* | | Give Details of type of Exercise |
|---|---|---|
| (At least 30mins x 3/week) Regularly | | |
| (Less than 30mins x 3/week)Occasionally | | |
| Never | | |

| **Medical History of Family** | | | |
|---|---|---|---|
| Has any close relative(parent/grandparent/brothers/sisters) had any of the following | | | |
| | **YES** | **NO** | **If Yes Who** |
| High Blood Pressure | | | |
| Angina/Heart Attack | | | |
| Stroke | | | |
| Asthma | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Cancer | | | |
| Eczema/Hayfever | | | |
| Glaucoma/Blindness | | | |
| Sudden Death | | | |

| **Carers** | | | |
|---|---|---|---|
| **Do you care for someone?** | **YES/NO** | **Does someone care for you?** | **YES/NO** |

| **What Is Your Ethnic Group? (*Choose one section and tick the appropriate box)*** | | | |
|---|---|---|---|
| **WHITE** British | | Any Other White Background | |
| | | | |
| **MIXED** White and Black Caribbean | | Any Other Mixed Background | |
| White and Black African | | | |
| White and Asian | | | |
| | | | |
| **ASIAN OR ASIAN BRITISH** Indian | | Any Other Asian Background | |
| Pakistani | | | |
| Bangladeshi | | | |
| | | | |
| **BLACK OR BLACK BRITISH** Caribbean | | Any Other Black Background | |
| African | | | |
| | | | |

| **CHINESE OR OTHER ETHNIC GROUP** | |
|---|---|
| Any Other Please Specify | |
| I refuse to answer this question | |

Would you be interested in being contacted for your view on the services provided by the Surgery in the future?
**YES / NO** ***(Delete as appropriate)***

If you wish to register for online services please ask at Reception.