New Patient Questionnaire

Please complete this form as fully as possible. The information will be of importance to provide you with good medical care until we receive your medical records.

Basic Details

Full name: Date of birth:

Address: Email address:

Telephone number: Mobile number:

Ethnic background:

Next of Kin

Name: Contact number:

Relationship to you:

Personal Profile:

Occupation: Marital status:

Weight: Height:

Are you a carer? Do you have a carer?

Is English your first language?

If not. What is your first language & do you need a translator?

Are you registered disabled?

Health Profile

Alcohol:

Do you drink?

If so, how many units do you drink a week? (1 unit = 1 glass wine / ½ pint of beer / one standard measure of spirits)

How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? Please circle.

Never Less than monthly Monthly Weekly Daily or almost daily

Smoking:

Do you smoke?

If yes…

How many do you smoke a day? Would you like help to stop?

If no…

Have you ever smoked? If you smoked previously, when did you stop?

Allergies:

Do you have any allergies? If so, please list below.

Current Medication & Health:

*if you have a printed sheet of your current medication from your previous GP then please attach / bring it along.

Drug Name Strength Dose Reason

Please allocate a pharmacy to collect your medication from:

Details of any over the counter medication:

Details of any other medical conditions not covered above:

Health History:

Please record any significant past illnesses, accidents, operations or other hospital admissions, including, if possible, the date on which they occurred or started. Females – please include any pregnancies.

Date Medical Event

Family History (please circle relevant statement)

Diabetes Stroke Heart Disease High Blood Pressure

Other - Please list any other major illnesses that run in your family

Females only:

Have you had a cervical smear test? If yes, please provide the year of the most recent test.

Have you had a mammogram? If yes, please provide the year of the most recent test.

Contact:

Would you be happy for the practise to contact you and send you appointments reminders by text/email message? Yes/No

Signed: Date: