Staff initials:……
GP Appointment:……..
HCA Appointment:……

New Patient Questionnaire

Thank you for taking the time to complete this questionnaire

It may be some time before we receive your medical record. In the meantime this questionnaire will give the doctors important information about your medical history and will help us to give a better service.

Have you been registered with this practice before? YES/NO

Todays Date:			
Surname:			
Forenames:			
DOB:			
Address:			
Home Telephone No: **Mobile:**			
Occupation:			
Marital Status:			
Next of Kin:		**Contact Details:**	
Place of Birth:			
Ethnic Origin:			
Main spoken language:			

ALCOHOL	YES/NO …… units per week	**SMOKE**	YES/NO …… cigs per day If you used to smoke and have now stopped please tell us when ……
YEAR OF LAST TETANUS			

Children only

HAD ALL IMMUNISATIONS BEFORE STARTING SCHOOL? YES/NO

HAD TETANUS/POLIO INJECTION BEFORE LEAVING SCHOOL? YES/NO

Women only

Have you ever been pregnant?	
Date of last smear test:	
Are you using contraception (if yes what form of contraception are you using?)	

Have you had any of the following medical problems?

Arthritis	Yes/No	Asthma	Yes/No
Cancer	Yes/No	Chronic Bronchitis	Yes/No
Depression	Yes/No	Diabetes	Yes/No
Epilepsy	Yes/No	High Blood Pressure	Yes/No
Thyroid trouble	Yes/No	Ulcer (duodenal/gastric)	Yes/No
Stroke	Yes/No	Tuberculosis	Yes/No
Heart Attack/Angina	Yes/No	Hearing Difficulty/ Hearing Impairment	Yes/No
Registered Blind	Yes/No	Hearing Aid	Yes/No

Do you have a family history of any of the following?

	If yes please state which family member			If yes please state which family member	
FH: Hypertension	Yes/No		FH: Diabetes	Yes/No	
FH: Heart Disease >60	Yes/No		FH: High Cholesterol	Yes/No	
FH: Heart Disease <60	Yes/No		FH: Asthma	Yes/No	
FH: CVA/Stroke	Yes/No		FH: Respiratory Diseas	Yes/No	
FH: Cancer	Yes/No				

Are you registered disabled? YES/NO (if yes please explain)

……

……

We are improving how we communicate with patients. Please let us know if you need information in a different format or communication support.

Do you have a carer? YES/NO (if so please give details)

Name of Carer: ……..
Address of Carer: ……..
Contact Number: ……

Are they registered with this practice? YES/NO

Have you had any other illness, accident or operation in the past? YES/NO (if yes please give details)

DESCRIPTION	HOSPITAL	YEAR

Do you have any medical problems at the moment i.e. are you under the care of a hospital specialist or are you being treated for anything? YES/NO (if yes please give details)

……..

……..

……..

Are you currently taking any medication? YES / NO

Please provide details of the medication you are taking in one of the following formats and attach to this questionnaire:

1. The right hand side of your previous prescription ☐
2. A print out from your previous GP surgery ☐
3. Boxes and containers showing <u>your</u> details and medication ☐

Do you have any allergies to any tablets/medicines? YES/NO (if yes please give details)

……

This section is to be completed at 1st assessment by Practice Nurse/Healthcare Assistant

Height: ……. Weight: ……BMI: ……..Waist Circumference:…….

Urinalysis……..