

**PLEASE NOTE!** IN ORDER TO ENSURE THE CARE YOU RECEIVE IS APPROPRIATE YOU **MUST** ATTEND A NEW PATIENT APPOINTMENT, OTHERWISE ONLY ONE WEEKS MEDICATION WILL BE PRESCRIBED AT ANY ONE TIME

**NEW PATIENT HEALTH QUESTIONNAIRE**

Date:	Place of birth:		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname:		Previous Surname (if any)		
First Name:		Date of Birth:		Age:
Full Address:				
Tel No: (Home)		Mobile No:		
Occupation:		School:		

NAME & TELEPHONE NUMBER FOR NEXT OF KIN:

Ethnicity:				
White	Asian	Black/Black British	Other	First Language
British <input type="checkbox"/>	Indian <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>	
Irish <input type="checkbox"/>	Pakistan <input type="checkbox"/>	African <input type="checkbox"/>	Other Ethnic <input type="checkbox"/>	
Other <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other <input type="checkbox"/>	Not stated	
	Other <input type="checkbox"/>		Prefer not to state <input type="checkbox"/>	

Are you allergic to any medicine or anything else?

Do you have heart problems?	Yes	No	Are you Diabetic?	Yes	No
Do you have Asthma?	Yes	No	Are you a Carer ?	Yes	No
Are you Disabled?	Yes	No	Do you have a Named Carer?	Yes	No

If you are taking any regular medication please attach your up-to-date repeat prescription form from your previous surgery - if this is not available you will need to book an appointment for a medication review with a Doctor or Nurse Practitioner

Immunisations (please give the dates)

Tetanus	Polio	Diphtheria	BCG
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Other (please specify)

**Lifestyle**

How many cigarettes or cigars do you smoke each day?

OR

If you are an ex smoker, when did you give up and how many did you used to smoke?

OR

If you have never smoked tobacco, please tick here ☐

What regular exercise do you take?

Do you have a special diet? (eg. Vegetarian, low fat

Medical History

Please list with approximate dates any serious previous illnesses, long term illness, major operations or disabilities

Are you currently under the care of a hospital? If so please indicate which hospital and give brief details					
Family History					
Have any of your close family i.e. parents or siblings had any of the following? (please specify family member)					
Asthma	Cancer	Epilepsy			
Diabetes	Glaucoma				
Heart Attack	High Blood Pressure				
High Cholesterol	Stroke				
Tuberculosis	Thyroid Problems				
Women Patients Only					
Number of Children and Ages					
Number of Pregnancies					
Have you had a Hysterectomy?			Date		
Current method of Contraception					
Date of last smear test			Result		
Have you ever had an abnormal smear?			Date		
Are you on HRT? (specify type)					
Have you had a Mammogram?	Date	Result			
Approximate Height			Approximate Weight		
Have you ever been registerd at this surgery before ?			Yes	No	
Have you ever been seen as a temporary resident this surgery before ?			Yes	No	
Are you sharing your home with any patients already registered at this surgery ?			Yes	No	
If yes, please give names:					
Do you have any other relatives already registered at this surgery ?			Yes	No	
If yes, please give names:					
SURGERY USE ONLY					
Confirmation of address seen?	Yes	No	Urine specimen bottle provided	Yes	No
Date of new patient check        /        /		Time                          am/pm			