

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"/>
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Surname:	Previous Surname (if any)
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First Name:	Date of Birth:	Age:
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Full Address:

Tel No: (Home)	Mobile No:
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Occupation:	School:
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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 registered 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