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** ☐	**Female** ☐
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 ☐	Indian ☐	Caribbean ☐	Chinese ☐	
Irish ☐	Pakistan ☐	African ☐	Other Ethnic ☐	
Other ☐	Bangladeshi ☐	Other ☐	**Not stated**	
	Other ☐		Prefer not to state ☐	

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

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**	