New Patient Questionnaire

Date of registration .....
Title..... Name.....
Date of Birth .....
Address ..... Post code.....
Nationality ..... Ethnicity.....
Tel No. Home ..... Work/Mobile.....
E-mail .....
Occupation.....
Approximate proposed time in this area…….. [State time or indefinite]
Are you a carer [see leaflet at desk if unsure]… Yes/No

Next of kin……Relationship……tel no…..……
Address……[For emergency use only]

Personal History
Have you ever had any of the following

	Yes	No	If so Date started
Heart problems	☐	☐	.....
Stroke	☐	☐	.....
Asthma /lung disease	☐	☐	.....
High Blood Pressure	☐	☐	.....
Diabetes	☐	☐	.....
[If diabetic on insulin]	☐	☐	.....
Epilepsy	☐	☐	.....
Thyroid problems	☐	☐	.....

Do you suffer from any other medical conditions YES/NO
If yes please give details……
……
……
Please give details of any operations /illnesses in the past
……
……
……..
Please complete the reverse of this form

Are you taking any medication [including oral contraception]
…….
……..
……..
Do you have any allergies ……

Females only. Have you ever had a smear test? YES/NO. If so when…...

Are you currently a smoker. YES/NO. If so how many a day……..
Are you an ex-smoker YES/NO . Date stopped ……How many…....

How many units of alcohol do you drink per week……
[One unit =half pint beer OR one glass of wine OR 1 pub measure of spirits]

Family history [only parents, brothers or sisters]
Have any suffered from

	Yes	No	Age started
Heart attacks/angina	☐	☐	……
Stroke	☐	☐	……
Diabetes	☐	☐	……

Other significant family illness…….

We recommend you make an appointment with the Practice Nurse to have a Blood Pressure check and discuss any health issues of concern, especially if you suffer from any of the diseases mentioned above. Please bring a urine specimen and any regular medication, including inhalers, with you. You will require to see the doctor before receiving initial prescriptions for repeat medication.

Office use only.

BP……. Urine Alb……..Gluc…….. Ht…….cm. Wt…….. Kg.