


**New Patient Questionnaire**

Please complete this simple questionnaire and along with your registration form.

Name: ..... DOB: .....

Address: .....

..... Post Code: .....

 Home: ..... Mobile: ..... Work: .....

Area moved from: ..... Occupation: .....

Members in household (e.g. mother, husband, son): .....

**Past Medical History**

Please list any operations, serious illness, fractures and chronic or recurrent health problems, e.g. high blood pressure, angina, diabetes, asthma, anxiety/depression. Please give approximate dates of onset.

- 1 ..... 4 .....
- 2 ..... 5 .....
- 3 ..... 6 .....

**Regular Medication**

Please list your regular medication below or bring your tablets or repeat prescription slip to your new patient check appointment.

- 1 ..... 4 .....
- 2 ..... 5 .....
- 3 ..... 6 .....

**Allergies / Drug Intolerances**

Please list any allergies and drug intolerance's known to you.

- 1 ..... 3 .....
- 2 ..... 4 .....

**Current Medical Health**

- Do you smoke?       No – Never  
                                  Ex-smoker – How much/many per day? .....
- Yes – How much/many per day? .....

If you would like to find out more about ways we can help you to stop smoking pick up a leaflet or make an appointment with the nurse in the stop smoking clinic on Friday afternoons.

How much alcohol do you drink **per week**? (please tick as appropriate)

How often do you have a drink that contains alcohol?       Never or less       Monthly       2 – 4 per month       2 – 3 per week       4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?       1 – 2       3 – 4       5 – 6       7 – 8       10+

How often do you have 6 or more standard drinks on one occasion?       Never       Less than monthly       Monthly       Weekly       Daily or almost daily

***Please turn over***

**Family History**

In order to consider appropriate screening tests we would be grateful if you could provide the following medical details regarding your immediate family (father, mother, brother, sister, grandparent).

Medical Problem	Y	N	Family Member	Maternal / Paternal	Age of Onset
1 DIABETES					
2 HIGH BLOOD PRESSURE					
3 HEART DISEASE (inc. angina, heart attacks, bypass operations)					
4 STROKES & TIA (mini-strokes)					
5 CANCER					
ANY OTHER MEDICAL FAMILY DETAILS... Please state:					

**Female Patients Only**

Approximate date of last smear – normal/any problems:

.....

Approximate date of last mammogram (aged 50+) – normal/any problems:

.....

**Any patients on regular medication need to see a GP before we are able to issue any further prescriptions, so please make an appointment at reception.**

We would like to offer all patients, but particularly those over 40 years, a health check with one of our nurses.

This would include height and weight measurements and a blood pressure check.

We can also arrange further blood tests for cholesterol and sugar if there is a family history of diabetes, heart disease or other factors that may put you at risk from these problems.

***Thank you for your time***

Admin Use Only:

------------------------------------------