**New Patient Questionnaire**

It may be some time before we receive your medical records. In the meantime, this questionnaire must be completed to give the doctors important information about your medical history and help us to give you a better service.

**Have you been registered with this practice before?** YES / NO

|  |  |
| --- | --- |
| **Surname** |  |
| **Forenames** |  |
| **Date of birth** |  |
| **Address** |  |
| **Telephone** | **Do you agree to text message reminders for appointments and results?** YES / NO |
| **Email** |  |
| **Occupation** |  |
| **Marital status** |  |
| **Place of birth** |  |
| **Ethnic origin** |  |
| **Main spoken language** |  |
| **Next of kin details** | **Do you agree to us contacting them?** YES / NO |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Height** |  | **Smoker** | YES / NO | **How many per day?** |  |
| **Weight** |  | **Ex-smoker** | YES / NO | **Quit date?** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How often do you drink alcohol?** | Never | Monthly/less | 2-4 times a month | 2-4 times a week | 4+ times a week |
| **How many alcoholic drinks do you have on a typical day?** | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |
| **How often do you have six or more drinks on one occasion?** | Never | Less than monthly | Monthly | Weekly | Almost daily |

**Are you a carer? Or do you have a carer?** YES / NO

If yes, please give details

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**Are you taking any medications?**

Please attach the right hand side of your previous prescription.

You will need to have a consultation with our in-house pharmacy team prior to obtaining any medications.

**Do you have any medical problems at the moment?** YES / NO

i.e. are you under the care of a hospital specialist or are you being treated for anything?

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**Are you registered disabled? Do you have any information or communication needs?** YES / NO

If yes, please elaborate

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**Do you have any allergies?** YES / NO

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**Have you ever had any of the medical problems below?**

If yes, please provide dates

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Asthma** | YES / NO |  | **Epilepsy** | YES / NO |  |
| **Cancer** | YES / NO |  | **Heart attack / angina** | YES / NO |  |
| **COPD** | YES / NO |  | **High blood pressure** | YES / NO |  |
| **Depression** | YES / NO |  | **Stroke** | YES / NO |  |
| **Diabetes** | YES / NO |  | **Thyroid trouble** | YES / NO |  |

**Do you have a family history of any of the following?**

If yes, please state which family member

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Asthma** | YES / NO |  | **Heart disease >60** | YES / NO |  |
| **Cancer** | YES / NO |  | **Heart disease <60** | YES / NO |  |
| **CVA/Stroke** | YES / NO |  | **High cholesterol** | YES / NO |  |
| **Diabetes** | YES / NO |  | **Hypertension** | YES / NO |  |
|  |  |  | **Respiratory disease** | YES / NO |  |

**Have you had any other illness, accident, or operation in the past?** YES / NO

If yes, please give details

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| **Patient signature** |  | **Date** |  |

**Thank you for taking the time to complete this questionnaire!**