

NEW PATIENT QUESTIONNAIRE



Please complete in CAPITAL letters and tick the boxes

Date

Name:

Date of Birth.....

Occupation:

Work No:

Mobile No:.....*

*Do you consent to receiving texts from the surgery on your mobile number provided? YES NO
 #9NdP – Y #9NdQ - N

Are you on any regular medication, including anything you buy over the counter?
YES **(list below)** **NO**

Is there any family history of heart disease / diabetes / hypertension (please circle). If yes, give details below -

Have you had any operations/serious illnesses in the past?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, please give details with dates
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Condition	PREVIOUS MEDICAL HISTORY		
	Have there been any instances of :		
	Please tick	Age Diagnosed	Date Diagnosed
Asthma			
Cancer / Type			
Diabetes			
Epilepsy			
Heart Disease			
High Blood Pressure			
Stroke			
Thyroid Disease			

Do you have any Allergies YES NO If yes, what are they -

Do you have any drug related allergies YES NO If yes, what are they -

Are you a carer? YES NO If yes for whom?.....

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Name of Pharmacy for Prescriptions to be sent.....

LIFESTYLE QUESTIONS

Please tick against the description that best matches your habits, in the tables A-F below

SMOKING – tick the answer which best applies		
Current smoker*	Never smoked	Ex Smoker
*If you have ticked this box, we recommend you try to stop smoking. Did you know that you are more likely to quit if you see a smoking cessation adviser? Interested? Pick up a self referral from reception.		

EXERCISE – tick the answer which best applies		
Exercise Physically Impossible	Avoid Trivial Exercise	Enjoys Light Exercise
Enjoys Moderate Exercise	Enjoys Heavy Exercise	Competitive Athlete

Language support	
Do you need sign language support?	Yes/No
Do you need an interpreter?	Yes/No
If yes, please state what language you speak	

Ethnic Origin:		
Bangladeshi <input type="checkbox"/>	Chinese <input type="checkbox"/>	Pakistan <input type="checkbox"/>
Black African <input type="checkbox"/>	Indian <input type="checkbox"/>	White British <input type="checkbox"/>
Black British <input type="checkbox"/>	Other Asian <input type="checkbox"/>	White Irish <input type="checkbox"/>
Black Caribbean <input type="checkbox"/>	Other ethnic origin <input type="checkbox"/>	White Scottish <input type="checkbox"/>
Black, other <input type="checkbox"/>	Other mixed origin ethnic <input type="checkbox"/>	Other white ethnic <input type="checkbox"/>

ALCOHOL –				
<i>GUIDE TO ALCOHOL UNITS</i>				
• Single shot gin/vodka/whisky=1 unit	• Pint beer/cider/lager=2 units			
• Standard glass of wine=2 units	• Large glass of wine=3 units			
MEN – How often do you have 8 or more units on one occasion – add up the number of units then tick answer below				
WOMEN – How often do you have 6 or more units on one occasion – add up the number of units then tick answer below				
0. Never	1. Less than monthly	2. Monthly	3. Weekly	4. Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?				
0. Never	1. Less than monthly	2. Monthly	3. Weekly	4. Daily or almost daily

How often during the last year have you failed to do what was normally expected of you because of drinking?				
0. Never	1. Less than monthly	2. Monthly	3. Weekly	4. Daily or almost daily

In the last year, has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?		
0. No	2. Yes, on one occasion	4. Yes, on more than one occasion