**NEW PATIENT QUESTIONNAIRE**

**\*\*This form must be brought with you for your New Patient Medical –**

**you will not be seen or able to register without it\*\***

We would be grateful if you could complete this questionnaire. It will help us to provide a better service for you if we know a little of your medical history and circumstances. Your previous records may take some time to reach us or may not contain all the information that we would find useful.

**DATE ISSUED TO PATIENT** ………………..

**1. PERSONAL DETAILS**

Surname: …………………………………………… Mr/Mrs/Miss/Ms/Other: …………

First Name: ……………………………………………. Date of Birth: ……………….

Address: …………………………………………………………………………………...

………………………………………………………………………………………………

Email Address: ……………………………………………. (We do not provide email medical advice)

Phone No: …………………………………… Mobile No: ……………………………...

Consent for SMS text messaging service: YES or NO

Are you a Carer for another person? Y or N If Y, whom do you care for? …………….

Does someone look after you (care for you)? If so, who is the person who looks after you?

……………………………………………………………………………….

**2. PERSONAL MEDICAL HISTORY**

Please circle any of the following conditions, if you suffer from them, or are receiving treatment for them.

Cancer … Of which part? ……………………….

Diabetes Heart Failure Angina

Heart Attack High Blood Pressure Irregular Heart Beat or Fibrillation

Stroke TIA or ‘mini stroke’ Migraine

Blindness/Glaucoma Deafness Blackouts, Fits or Faints

Epilepsy Asthma Thyroid problems

COPD/Emphysema/chronic bronchitis Splenectomy

Schizophrenia Coeliac

Pernicious Anaemia or Vitamin B12 Deficiency Sickle Cell or Thallasaemia

Hepatitis B Hepatitis C

Any other serious long term disorder? ……………………………………

**3. FAMILY HISTORY**

Have any of your parents, brothers or sisters suffered from any of these or any other inherited condition? Please tell us especially about bowel, breast and ovarian cancers, and problems to do with blood clots, thyroid, coeliac disease or gluten and heart problems especially at a young age.

Please give details: ………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

**4. MEDICAL SUMMARY**

Please list any serious illnesses, any hospital admissions or operations you have had since birth. e.g. tonsils, appendix, broken bones, joint replacements, pacemaker or other implants, gall bladder, hernia,

|  |  |
| --- | --- |
| Date | Condition |
|  |  |

**5. LIFESTYLE**

**5a – Alcohol**

I am lifelong teetotal. I never drink alcohol or only ever on exceptional occasions.

I used to drink …….. pints of beer/lager, ……….. glasses of wine, or …………. measures of spirits weekly but I gave up on ……………….

I currently drink …….. pints of beer/lager, ……….. glasses of wine, or …………. measures of spirits weekly.

**5b – Smoking**

I have never smoked

I stopped smoking in …………. (year)

I currently smoke (please circle as appropriate) Cigarettes Pipe Cigars Snuff

What quantities daily: Cigarettes ……. oz Tobacco ………. Cigars ………….

Would you be interested in stopping smoking YES / NO

(if yes, please speak to one of the Receptionist or Clinical staff who can help explain options available to assist you with stopping)

**5c – Exercise**

Do you exercise? YES / NO

If yes, what exercise to you do? ………………………………………………………………………..

If no, what prevents you from exercising? ……………………………………………………………….

What is your weight? …………………………….

What is your height? ……………………………..

**6 ALLERGIES**

Do you have any allergies to any drugs or any medicines? YES / NO

Please list any allergies:

………………………………………………………………………………….

**7 MEDICATION**

***PLEASE BRING A COPY OF YOUR REPEAT LIST FROM PREVIOUS GP***

Are you receiving regular medication? Please list all your medication or attach a repeat prescription form from your previous Doctor.

|  |  |  |
| --- | --- | --- |
| Name of Medicine | Strength | Dose |
| *i.e. Aspirin* |  *75mgs* | *Once daily* |

If you receive regular medication and wish us to forward your prescription to a local pharmacy, of your choice, for you to collect, we require your consent to do this.

Please sign below, if you agree to us forwarding your prescription on your behalf.

(you can opt out of this arrangement at any time)

**Consent to send prescription/discuss your medication with your chosen Pharmacy:**

**Patient signature: ……………………………………………………………………….**

**Date: ……………………………………….**

**8. FEMALES**

Are you on the Oral Contraceptive Pill? YES / NO

Do you have a contraceptive Implant? YES / NO

Do you have an IUD (coil)? YES / NO

When was your last cervical smear test? …………………………………………..

What was the result of this test? …………………………………………………….

Mammography/breast screening – all women over the age of 50 are invited every 3 years for a routine mammogram. Routine invitations cease at the age of 70. If you require any further advice regarding mammography, please ask a member of the clinic staff.

Pregnancy – please make an appointment to see the practice Midwife, as soon as possible, if you are at any stage of pregnancy.

**9. ETHNICITY**

To which ethnic group do you belong?

|  |  |  |  |
| --- | --- | --- | --- |
| White British | White Irish | Other White Ethnic Group |  |
| Black Carribean | Black African | Black Carribean and White | Black African and White |
| Indian | Pakistani | Bangladeshi | Chinese |
| Asian and White | Other Black ethnic grp | Other mixed origin | Other Asian ethnic grp |

Other Ethnic Group – please state ………………………….. …………….

 I do not wish to record my ethnic group

Patient’s Signature: …………………………………………Date: ……………………..

Thank you for taking the time and trouble to complete this form.

**FOR OFFICE USE ONLY**

|  |  |
| --- | --- |
| BP Reading |  |
| Urinalysis  |  |
| Completed by: Date:  | KM JMac JM KiM……………………………. |

Ethnic Coding, an explanation.

The Race Relations (Amendment) Act 2000 places a duty on public authorities to promote race equality. NHS Primary Care Trusts have a duty to collect and publish sets of information relating to the ethnicity of employees and they must consult and monitor the impact of policies and services on the promotion of race equality. This will help monitor equity of access, delivery and outcomes for all service users.