New Patient Questionnaire

We would be grateful if you could complete this form when you register with our practice. It usually takes a number of weeks before your medical records arrive, so this form can help us with essential medical information about you.
The information you supply will be treated with the strictest confidence, but if there is anything you would prefer not to answer then please leave the relevant section blank.
If you have any difficulty with any of the questions the receptionists may be able to help.

Have you been registered with this practice at any time in the past? Yes □ No □
If yes, what year did you leave this practice? _____

Surname: _____ Title: Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Other _____
Forenames: _____ Sex: Male □ Female □
Address: _____ Marital status: Single □ Married □ Widowed □
_____ Divorced □ Separated □
_____ Ethnic Origin: British or mixed British □ European □
Postcode: _____ Afro Caribbean □ Chinese □
NHS No: _____ Indian □ Other (please state) _____
Date of birth: _____ Main Spoken Language _____
Carers: Do you look after a relative, friend or partner, who
Telephone: _____ is ill, frail or disabled? _____
Mobile: _____ _____
Email Address: _____

I wish to register for Online Services (e.g. appointment booking, repeat prescription requesting) Yes □ No □
I wish to be contacted by the Practice via text/email Yes □ No □

Data Sharing

I wish for my medical records to be uploaded to the Summary Care Record (SCR) system Yes □ No □
I wish for my medical records to be shared Health & Social Care Information Centre Yes □ No □
I wish for my medical records to be shared with other health professionals Yes □ No □
(If you answer No to either of the above questions about data sharing, please complete the relevant form(s), available from Reception)

Name(s) of other persons living in house: _____

Past Medical History

Past Medical Problems	Year
1.	
2.	
3.	
4.	
5.	

Have you had any of the following?			
Diabetes	□	Jaundice	□
Heart disease / Stroke	□	Arthritis	□
Rheumatic fever	□	Asthma	□
Kidney disease	□	Epilepsy	□
High blood pressure	□	T.B.	□

Previous Operations

Please list all previous operations	Year	Place
1.		
2.		
3.		
4.		
5.		

Vaccinations - *type*		Year
Tetanus	□	
Polio	□	
Hepatitis A	□	
Hepatitis B	□	
Influenza	□	

Drugs and medication history

Are you taking any drugs? *(Include inhalers, creams, contraception, aspirin, hormones, eye drops and drugs bought regularly from the chemist)*		
Name	Dose	How often?
1.		
2.		
continued		
3.		
4.		
5.		

Are you allergic to any drugs?	
Name	Adverse effect

Do they have any other allergies?

Family History

	Alive + well	Alive + problem	Illness or problem	Deceased	Age at death	Cause of death
Father	□	□		□		
Mother	□	□		□		
Brothers	□ □ □	□ □ □		□ □ □		
Sisters	□ □ □	□ □ □		□ □ □		

Do any of your relatives *(blood relations only)* have any of the following illnesses?

Heart disease starting before age 60 □ Heart disease starting after age 60 □ Diabetes □ Glaucoma □

Asthma □ Thyroid disorder □ High blood pressure □ High cholesterol □ Osteoporosis □ Breast cancer □

Other cancer (Please specify)_____Other problems_____

Next of Kin Name	Relationship	Address & Contact number

Social information

Have you ever smoked? Yes □ No □
If Yes, do you still smoke? Yes □ No □ If Yes, how many do you smoke a day? If No, what year did you stop

Do you drink alcohol? Yes □ No □
If yes, how many units per week? Units (1 unit =half pint of beer =glass of wine =pub measure of spirit)

What is your occupation? Present job_____ Previous jobs_____

Female section

How many pregnancies have you had? _____ How many children have you had? _____

Year	Problems in pregnancy? e.g. blood pressure	Type of delivery	Premature? How early?	Weight	Name

When was your last cervical smear?(please let us know month and year) _____

Have you ever had an abnormal cervical smear? (details please) _____