

New Patient Questionnaire

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

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

Todays Date:			
Surname:			
Forenames:			
DOB:			
Address:			
Home Telephone No:			
Mobile:			
Occupation:			
Marital Status:			
Next of Kin:		Contact Details:	
Place of Birth:			
Ethnic Origin:			
Main spoken language:			

ALCOHOL	YES/NO units per week	SMOKE	YES/NO cigs per day If you used to smoke and have now stopped please tell us when
YEAR OF LAST TETANUS			
<i>*Children only</i>			
HAD ALL IMMUNISATIONS BEFORE STARTING SCHOOL? Yes/No			
HAD TETANUS/POLIO INJECTION BEFORE LEAVING SCHOOL? Yes/No			
<i>*Women only</i>			
Have you ever been pregnant?			
Date of last smear test:			
Are you using contraception (if yes what form of contraception are you using?)			

Have you had any of the following medical problems?

Arthritis	Yes/No	Asthma	Yes/No
Cancer	Yes/No	Chronic Bronchitis	Yes/No
Depression	Yes/No	Diabetes	Yes/No
Epilepsy	Yes/No	High Blood Pressure	Yes/No
Thyroid trouble	Yes/No	Ulcer (duodenal/gastric)	Yes/No
Stroke	Yes/No	Tuberculosis	Yes/No
Heart Attack/Angina	Yes/No		

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

	If yes please state which family member		If yes please state which family member
FH: Hypertension	Yes/No	FH: Diabetes	Yes/No
FH: Heart Disease >60	Yes/No	FH: High Cholesterol	Yes/No
FH: Heart Disease <60	Yes/No	FH: Asthma	Yes/No
FH: CVA/Stroke	Yes/No	FH: Respiratory Diseases	Yes/No
FH: Cancer	Yes/No		

Are you registered disabled? YES/NO (if yes please explain)

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Are you a carer? YES/NO (if yes do you care for any of the following)

Carer of a person with learning disability	Yes/No	Carer of a person with chronic disease	Yes/No
Carer of a person with physical disability	Yes/No	Carer of a person with mental health probs	Yes/No
Carer of a person with sensory impairment	Yes/No	Carer of a person with a terminal illness	Yes/No
Carer of a person with substance misuse	Yes/No	Other	Yes/No
Carer of a person with alcohol misuse	Yes/No		

Have you had any other illness, accident or operation in the past? YES/NO (if yes please give details)

DESCRIPTION	HOSPITAL	YEAR

Do you have any medical problems at the moment i.e. are you under the care of a hospital specialist or are you being treated for anything? YES/NO (if yes please give details)

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Please list any tablets/medicines you are taking or attach the right hand side of your previous prescription

Name of tablet/medicine	Dose/strength	Daily amount

Do you have any allergies to any tablets/medicines? YES/NO (if yes please give details)

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Thank you for taking the time to complete this questionnaire

This section is to be completed at 1st assessment by Practice Nurse/Healthcare Assistant

Height: Weight: BMI:

Waist Circumference: Urinalysis:
