

NEW PATIENT QUESTIONNAIRE

SURNAME: (Mr/Mrs/Miss/Ms.....)

FORENAME(S):

PREVIOUS SURNAME(S): DATE OF BIRTH

ADDRESS:

TELEPHONE NO: ETHNIC ORIGIN

PLACE OF BIRTH: FIRST SPOKEN LANGUAGE

OCCUPATION:..... MARITAL STATUS:

NEXT OF KIN:
(including address and telephone number)

ARE YOU A WAR VETERAN? IF SO, OF WHICH SERVICE?

FAMILY MEMBERS REGISTERED WITH THIS PRACTICE :
.....

Please list any health problems that affect you now:-

Please list any current medication, including contraceptive pill, inhalers, ointments:-

Please list any operations and serious illnesses you have had in the past, with dates:-

Are you allergic to any medication?

What is your weight? What is your height?

When were you last immunised against: Tetanus

Polio

Please give dates of pre-school immunisations for children:

Have you had Rubella immunisation? Give date

Blood test shows immunity(tick if appropriate)

When did you last have a cervical smear test? Give date

Result (if known) Never had a smear test (tick)

Please list all pregnancies, including any miscarriages:-

Year

Birth, miscarriage and any complications

Do you currently smoke? Have you ever smoked?

*****TOBACCO SERIOUSLY DAMAGES YOUR HEALTH*****

MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

(N.B. 1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits)

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 or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

0 Never 1 Less than monthly 2 Monthly 3 Weekly 4 Daily or almost daily

FAMILY HISTORY

Have your mother, father, brothers, sisters or children under 65 suffered from or died from -

Heart disease : Yes No Stroke: Yes No

High blood pressure: Yes No Diabetes: Yes No

Other serious illness

Signature Date