

## NEW PATIENT QUESTIONNAIRE

Welcome to our surgery. As we can only hope to give a good service with the co-operation of our patients would you please complete all of the following questions as fully as possible? This enables us to know a little about your previous medical history until your records are received. We hope that you will be happy with us but if you have any concerns please make them known to the Practice Manager as soon as possible.

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Today's Date .....  
Surname ..... First name/s ..... Sex M/F  
Address.....  
Post Code ..... Telephone number .....  
Date of birth ..... Marital status S/M/D/W/Living with partner. ....  
Place of birth ..... Occupation.....  
Ethnicity..... Main Language spoken..... Do you require an interpreter? Y / N  
Do you have a sensory impairment (deafness etc) or disability? If yes please state

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Do you have an assistance dog? Y / N Do you have difficulty accessing our building? Y / N  
Do you smoke Y/N/Never? If yes how many per day ..... Would you like help to stop? Y/N  
If you are an ex-smoker how many did you used to smoke? ..... What year did you stop? .....  
Do you drink alcohol? Y/N/Never. If yes how many units per week (1/2 pint, one measure = 1 unit)? .....  
How tall are you? ..... How much do you weigh? .....  
If you feel you are over weight would you like any dietary advice? Y/N  
How many times do you exercise each week? 1/2/3/4+

Due to the new registration process each new patient over the age of 14 **must have a blood pressure/urine check**. This can be done simply and only takes a few minutes with our Health Care Support Worker but if you suffer from any of the following you will need a slightly longer check-up with the Practice Nurse. Please circle all of the following which apply to you:

- Coronary heart disease (this includes angina and all heart problems) Y/N
- Hypertension (high blood pressure) Y/N
- Diabetes including dietary controlled Y/N
- Epilepsy Y/N
- Hypothyroidism Y/N
- Severe mental health problems Y/N
- Asthma or chronic obstructive pulmonary disease Y/N
- Stroke/TIA Y/N

Have you had any recent medical problems? If so what?

If you are on regular medication **please bring your prescription request slip with you** including any not prescribed by you previous doctor. Do you have any known allergies? Y/N Please provide details.....

Please list all other major illness you might have suffered in the past:

Is there a history in your immediate family (parents, brother or sister) of any of the following?

- Heart attack: under 65 years of age Y/N, over 65 years of age Y/N
- Diabetes Y/N
- Asthma Y/N
- Stroke/TIA Y/N
- High blood pressure Y/N
- Breast cancer Y/N, bowel cancer Y/N
- Glaucoma Y/N

Are you the primary carer for a member of your family who has a disability or long term illness? Y/N  
Do you have a carer yourself? Y/N

**Have you, at any time, been a patient at the surgery in the past (temporary or permanent)? Y/N**

**Please note:**

**It is extremely important for you to arrange a registration medical appointment as soon as possible after registering with the surgery. At this appointment we will ask about your medical history, any medication you are taking, check your blood pressure, weight and urine and you will have an opportunity to find out more about the practice and the services we offer.**