



FRESSINGFIELD MEDICAL PRACTICE

DR GREGORY READ • DR JAMES MORRIS • DR FAISAL MANTO

www.fressingfield-medical-practice.co.uk

NEW PATIENT QUESTIONNAIRE

FULL NAME

DATE OF BIRTH COUNTRY OF BIRTH

ADDRESS

..... POSTCODE.....

TELEPHONE NO: HOME MOBILE WORK

Please indicate contact preference

E-MAIL ADDRESS:..... OCCUPATION.....

MARITAL STATUS : NEVER MARRIED / MARRIED / DIVORCED / WIDOWED

SOCIAL: ARE YOU A CARER? YES / NO

DO YOU HAVE A CARER YES / NO

ALCOHOL STATUS : HOW MANY UNITS DO YOU DRINK PER WEEK?.....

1 UNIT = 1 SMALL GLASS OF WINE OR 1 SINGLE MEASURE OF SPIRITS OR 1/2 PINT OF BEER/CIDER

EXERCISE : HOW MUCH AEROBIC TYPE EXERCISE DO YOU DO?.....

AEROBIC TYPE EXERCISE = SWIMMING / CYCLING / WALKING / JOGGING

0 TIMES PER WEEK

1 TIME A WEEK

2 TIMES PER WEEK

3 TIMES PER WEEK

MORE THAN THE ABOVE

ALLERGIES : ARE YOU ALLERGIC TO ANYTHING? YES / NO

IF YES PLEASE LIST.....

MEDICATION: DO YOU TAKE ANY TABLETS / MEDICINES REGULARLY? YES / NO

IF YES PLEASE ATTACH A REPEAT MEDICATION FORM FROM YOUR PREVIOUS PRACTICE AND LIST ANY OTHERS NOT ON LIST

E.G COMPLIMENTARY OR OVER THE COUNTER MEDICINES Etc