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DR. R DHATARIYA • DR. J S SHARMA • DR. S NEHRU

PATIENT QUESTIONNAIRE

This set of questions has been designed to help your new General Practitioner get to know you and your medical problems.

The information you provide will be handled confidentially by your doctor but if you are concerned about any of the questions please leave them blank.Your doctor will be pleased to clarify any points.

It will be appreciated if you can return the completed forms to the surgery as soon as possible before your New Patients Medical.

It is most important that you bring your urine sample with you.

Surname ..... First Name ..... Mr/Mrs/Miss Date of Birth .....

Present Address .....

..... DAYTIME Tel./ Mobile No. .....

E-mail .....

Previous Address .....

Name and address of previous doctor: Dr. .....

Address .....

..... Tel. No. .....

Are you: Single - Married - Divorced - Separated - Remarried - Widowed - Cohabiting? *(please delete)*

Date when questionnaire completed .....

WHAT IS YOUR ETHNICITY

White		**Mixed**		**Asian or Asian British**		**Black & Black British**	
British	A	White & Black Caribbean	D	Indian	H	Caribbean	M
Irish	B	White & Black African	E	Pakistani	J	African	N
Any White Background	C	White & Asian	F	Bangladeshi	K	Any other Background	P
		Any other mixed background	G	Any other Asian background	G	**Other Ethnic Groups**	
						Chinese	R
						Any other Ethnic group	S
						Ethnicity not Recorded	Z

Please list any medicines or tablets you are taking at present. Please attach the computer slip of any repeat medication from your previous Doctor.

ILLNESSES, ACCIDENTS or OPERATIONS

Please list all SERIOUS ILLNESS, ACCIDENTS, HOSPITAL ADMISSIONS or OPERATIONS.
Are you suffering with any illness at present. *(please write below)*

ALLERGIES

Are you allergic or sensitive to any medicines, food, animals etc?

IMMUNISATIONS

Please tick if you have been immunised against the following illnesses, and if possible give the dates of last vaccination.

		DATE			DATE			DATE
Diptheria			MMR			Polio		
Smallpox			Tetanus			Influenza		
German Measles			Tuberculosis					
Typhoid Fever			Whooping Cough					

SMOKING & ALCOHOL

How much do you smoke each day? Cigarettes .....Cigars ..... Pipe .....

How much alcohol do you drink each week? .....

WEIGHT

What is you weight now?.....

HEIGHT

What is your height?.....

EXERCISE

Inactive ☐ Gentle ☐ Moderate ☐ Vigorous ☐ *(please tick)*

OCCUPATION

What is your occupation?.....

What does your job actually entail? .....

.....

What other jobs have you had in the past? .....

FAMILY HISTORY

Do you or any of your family or close relations have any or the following illnesses or conditions?

	YES or NO	Please give details
Sugar Diabetes		
High Blood Pressure		
Heart Attack		
Stroke		
Epilepsy or Fits		
Asthma		
Nervous Disorders		
Congenial Diseases		
Cancer		
Kidney Disease		

Are your parents still alive and in good health?

Mother ..... Father .....

(If either has died could you please say how old they were when they died and what was the known cause of death).

Please list your *brothers and sisters* with their ages and give details of any serious illnesses they have suffered.

Is there any other information you may think be helpful?

Do you suffer any disabilities? YES ☐ NO ☐

If YES, do you have a carer? Please give name & address of your Carer.

.....

Are you Main Carer of anybody? Please give name & address of whom you Care for.

.....

WOMEN ONLY

PERIODS

At what age did your periods start? .....

finish?..... (If relevant)

Are your periods regular? .....

How many days in the cycle?.....

How long does the bleeding last? .....

Is the bleeding heavy? .....

How much pain do you get with your periods?:-

Little ..... Moderate ..... A lot .....

Do you use contraceptives? The Pill
Intra-uterine Coil
Diaphragm
Sheath
Other Methods

If you use the Pill - for how long have you been taking it? .....

Do you get any side effects? .....

Have you had a cervical (cancer) smear? .....

What was the date of the last one? .....

CHILDREN

Please list all children that you have had:-

Name	Date of Birth	Difficulties with pregnancy or birth (and birth weight if known)

Have you had any miscarriages? - Please give details

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