Rastrick Health Centre

New Patient Questionnaire

Our doctors would like to invite you to fill in this questionnaire. Some of this information will go onto our clinical computer system. This information will help us to provide you with high quality clinical services and will be treated with the utmost confidentiality.

Personal details	
Name:	
Address:	
Postcode:	
Date of Birth:	
Telephone No:	
Mobile No:	
Email Address	

Medical details	
Height:	
Weight:	

Past Medical History	
Please detail any significant past medical history that you feel we should be informed of:	

Family History	
Please detail any significant family history that we should be informed of (eg. Asthma, diabetes, epilepsy, stroke, heart attack)	

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Disability Status	
Do you have a physical disability?	Yes/ No
Do you have a learning disability?	Yes/ No
If you answered yes to either of the questions above please add any further information about your disability that you feel we should be informed of.	

Are you a carer?	Yes/ No	Are you housebound	Yes/ No

How would you describe yourself ?			
White British		Asian or Asian British - Indian	
White Irish		Asian or Asian British - Pakistani	
Any other white background		Asian or Asian British - Bangladeshi	
Mixed - white and black Caribbean		Asian or Asian British – any other Asian background	
Mixed – white and black African		Black or black British- Caribbean	
Mixed – white and Asian		Black or black British - African	
Mixed – any other mixed background		Black or black British –any other black background	
Prefer not to state ethnicity		Other ethnic groups - Chinese	
		Other ethnic groups – any other ethnic group	

First Language

Religion

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Medication	
Please list any prescribed medication you are currently taking:	(Please attach a list of repeat prescription list if possible)

Over the counter Medication	
Please list over the counter medication that you take on a regular basis:	

Allergies (Including the drug)	
Please list any allergies that you have:	

Female patients	
Have you had a hysterectomy?	Yes / no Date:
When was the last smear test?	Date:
Do you know the result?	
When was your last mammogram (only applicable if you are over 50 yrs of age)	Date:
Do you know the result?	

Please fill out this form and hand in at reception with your registration form. You will be asked to make an appointment for a New Patient Health check.

Thank you for your co-operation.