NEW PATIENT QUESTIONNAIRE

Surname:

Forename:

Address:

DOB:

Home Phone:

Mobile Phone:

E-mail Address:

Next of Kin/ Carer:

Name:

Relationship:

Address:

Tel No:

Current problems

Past Medical History *(illnesses/ operations with dates)*

Relevant Social History

Any Family Illness *(Angina, Blood Pressure, Heart Attack, Diabetes, Stroke, Cancers – please give details)*

Current Smoking status Never Smoked ☐ Current Smoker ☐ Ex-Smoker ☐

Cigarette Consumption ………… cigarettes/ day

Alcohol Consumption …………. units/ week

Height …………………………… **Weight** …………………………………

Do you have a well-balanced diet YES ☐ NO ☐

Do you have two to three, 20 minute sessions of exercise per week YES ☐ NO ☐

Please list all current medication

Do you have any allergies *(please list)* YES ☐ NO ☐

What is your current occupation

Have you had any jobs in the past that may have affected your health *(please give details)*

Who do you have at home with you

Are you significantly involved with the care of a dependent relative *(please give details)*

Under 18's

Name of School or Nursery ………………………………………………..

Immunisation History

Main language …………………………………

Interpreter required ☐

Religion …………………………………………………

I would describe my ethnic origin as follows

White

- ☐ British
- ☐ Irish
- ☐ Any Other White Background

Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any Other Mixed Background

Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any Other Asian Background

Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any Other Black Background

Other Ethnic Groups

- ☐ Chinese
- ☐ Any Other Ethnic Group

Not Stated

- ☐ Not Stated