Wakering Medical Centre

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire as fully as possible. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It often takes us several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

The completed form must be returned to reception with your other registrations forms. The health care assistant (or nurse) will need to go through it with you at your new patient check appointment. This information will be held in your personal health record which, like all NHS records, remains confidential.

PERSONAL DETAILS	
Surname:	**First name(s):**
Previous surname(s):	**Sex:** Male/female **Title:** Mr/Mrs/Miss/Ms/Dr/Other
Date of birth:	**Occupation:**
Home address:	
Home tel:	**Mobile tel:**
Work tel:	**Email:**
We may occasionally want to contact you to remind you of an appointment. Do you consent to us contacting you by SMS text message? Yes/no Do you consent to us contacting you by email? Yes/no	
CONTACT DETAILS OF YOUR CARER (IF APPLICABLE)	
Name:	
Contact number(s):	
PREVIOUS GP	
Name of last GP:	**Telephone:**
Address:	

CARERS
Do you look after or support someone who is ill, frail, disabled or mentally ill? Yes/no
Are you looked after or supported by somebody because you are ill, frail, disabled or mentally ill? Yes/no
If you answered 'yes' to either of these questions, please ask at reception for more information.

HEALTH INFORMATION	
Height:	**Weight:**
Do you smoke? Yes/no Cigarettes/cigars/pipe/roll-ups	**If yes, how many per day?**
Have you ever smoked? Yes/no	**If you have stopped smoking, give approximate date you stopped:**
We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of our smoking cessation services.	
Do you have any allergies? animals/pollen/nuts/medication/other (please specify)	
Have you ever suffered from a bad reaction to any medication? Yes/no If yes, please give details:	
What medication do you currently take? (include all prescription and over the counter):	
What regular exercise do you take?	
How often do you have a drink that contains alcohol? Never Monthly or less 2-4 times per month 2-3 times per week 4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking? 1 - 2 3 - 4 5 - 6 7 - 8 10+	
How often do you have 6 or more standard drinks on one occasion? Never Less than monthly Monthly Weekly Daily or almost daily	

PERSONAL & FAMILY MEDICAL HISTORY	
Please give details of any serious illness, accident, ongoing condition, operations or special needs including dates:	
For Women	**For Men**
Do you use contraception? Yes / No **If Yes Please state which type.** **Hysterectomy Yes / No** **(If yes) Date: ---------------**	**Have you had a Vasectomy? Yes / No** **(If yes) Date: ---------------**

Have any close relatives (parents, brothers, sisters or children) suffered from any of the following or died before the age of 65? Please specify the disease and their relationship to you. ***Heart disease (heart attacks/angina)?*** ***Stroke?*** ***Cancer?*** ***Asthma/COPD?*** ***High Blood Pressure?*** ***Epilespy?*** ***Diabetes?*** ***Thyroid disease?*** ***Other?***	
Date of last cervical smear:	**Date of last tetanus vaccination:**
Date of last blood pressure check:	**Date of last cholesterol check:**
Date of last flu vaccination:	**Date of pneumococcal vaccination:**

School Age Children	
Name of School:	**Address:**

Summary Care Record
Do you know about summary care records? Yes / No (if no please ask reception) **Do you have a summary care record? Yes / No** **Do you want a summary care record? Yes / No**