Northcote Surgery New Patient Questionnaire

EMIS NO._____

Personal Details

Date: .....

Surname: ..... **First Name(s)** .....

Maiden Name: ..... **Parent/Guardian Name:** .....
(If applicable) *(If under 16)*

Date of Birth: ..... **Marital Status:** .....

Address: ..... **Home Telephone NO.:** .....

..... **Work Telephone NO.:** .....

Postcode: ..... **Mobile Telephone NO.:** .....

Occupation: ..... **Email Address:** .....

Country of Origin: ..... **Ethnic Group:** .....

If from abroad/or you have been a resident in another country please enter the date of entering/returning to UK: .....

Next of Kin: ..... **Next Of Kin Relationship:** .....

Address: ..... **Home Telephone NO.:** .....

..... **Work Telephone NO.:** .....

..... **Mobile Telephone NO.:** .....

Postcode: .....

Text Reminder Service

The surgery offers a text reminder service for appointments and requests for health updates (this service is currently only available to patiens aged 16 and over). **Please tick the box if you consent receiving text information regarding appointments and health updates** ☐ (For staff use alert code: Yes 9NdP or No 9NdQ)

Online Services

The surgery is now able to offer an online facility for you to book appointments* and to request your repeat prescriptions.
If you are interested please speak to a member of staff or see www.northcotesurgery.com for details. *Terms & Conditions apply*
** Not all appointments are available online.*

Medical Information

	NO	YES	
Do You Have a Carer?	☐	☐	(If Yes Please Provide Carers Name and Contact NO.:) .....
Are You a Carer?	☐	☐	(If Yes who for i.e. friend/mother etc:) .....

Do You Suffer From Any Of The Following Conditions:

Allergies Drug	☐	☐	(If Yes From What Drugs:) .....
Allergies Food	☐	☐	(If Yes From What Foods:) .....
Angina	☐	☐	(If Yes From What Date/Year:) .....
Arthritis	☐	☐	(If Yes From What Date/Year:) .....
Asthma	☐	☐	(If Yes From What Date/Year:) .....
Anxiety/ Depression	☐	☐	(If Yes From What Date/Year:) .....
Bowel Disorder	☐	☐	(If Yes From What Date/Year:) .....
Chronic Bronchitis	☐	☐	(If Yes From What Date/Year:) .....
Diabetes	☐	☐	(If Yes From What Date/Year and **Type 1 or 2**:) .....
Eczema/ Dermatitis	☐	☐	(If Yes From What Date/Year:) .....
Epilepsy	☐	☐	(If Yes From What Date/Year:) .....
Hay Fever	☐	☐	(If Yes From What Date/Year:) .....
Heart Failure	☐	☐	(If Yes From What Date/Year:) .....

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	NO	YES	
High Blood Pressure	☐	☐	(If Yes From What Date/Year:) .....
Mental Health Conditions	☐	☐	(If Yes From What Date/Year And Condition:) .....
Peptic Ulcer Disease	☐	☐	(If Yes From What Date/Year:) .....
Psoriasis	☐	☐	(If Yes From What Date/Year:) .....
Thyroid Disease	☐	☐	(If Yes From What Date/Year:) .....

Please List Any Other Conditions That Are Not Mentioned: .....

.....

.....

General Information

Smoking Status

	NO	YES	
Current Smoker	☐	☐	(If Yes From What Date/Year And Number Per Day:) .....
EX-Smoker	☐	☐	(If Yes From What Date/Year Stopped:).....
Never Smoked	☐	☐	

Alcohol Intake

	Wine	Beer	Spirits
Number Of Units Consumed Per Week	☐	☐	☐
	1 Glass of wine = 1unit	***1 Pint = 2 units***	***1 Measure = 1 unit***

Exercise

What type of exercise are you involved with: General☐ Running ☐ Swimming ☐ Aerobic ☐ Cycling☐ Other ☐

Other Than General How Many Times Per Week Do You Do This: 1☐ 2☐ 3☐ 4☐ 5+☐

Please List Any Medication You Are Currently Taking Or Please Enclose A Copy Of Your Last Repeat Slip

Name Of Drug	**Dose /Strength**	**Reason**
.....	.....	.....
.....	.....	.....

Family History

Have Any Of Your Blood Relations Suffered From: (*If Yes Please State the Relative And Age If Known*)

Heart Disease: ..... Diabetes ..... High Blood Pressure .....

Breast Cancer: ..... Bowel Cancer: ..... Stroke: .....

Other Serious Illness: .....

Female Patients Only

Have You Had Any HPV Vaccines? **1st** ☐..... **2nd** ☐ ..... **3rd** ☐.....

Do You Have Any Children **NO** ☐ **YES** ☐ (If Yes Please State the Number And Ages).....

Have You Had Any Miscarriages **NO** ☐ **YES** ☐ (If Yes Please State the Number) .....

Have You Had Any Terminations **NO** ☐ **YES** ☐ (If Yes Please State the Number) .....

Have You Had A Hysterectomy **NO** ☐ **YES** ☐ (If Yes Please State the Type and Year) .....

When Was Your Last Smear Test And Result: .....

Which Method Of Contraception Are You Using At Present: .....

Consent

In order to meet data protection requirements do you consent to your personal data being shared with the following organisations in order to assist in your healthcare (**Please circle below)**:

- Other NHS departments/organisations; Private healthcare service providers i.e. pharmacy, private hospitals **Yes/No**

(For Staff use alert code: Yes 9NdG or No 9NdH)