



The Neville Family Medical Centre

25 Old Market Street, Blackley, Manchester, M9 8DX

Tel: 0161 721 4865 | Fax: 0161 740 6532 | Website: [www.nevillefmc.com](http://www.nevillefmc.com)

## New Patient Questionnaire

Please use BLOCK CAPITALS and answer all questions. The information provided will form part of your medical record.

If you are returning from the **Armed Forces**, or if you are a **Carer**, please let us know.

### Section 1 - Personal Details

- |   |   |
|---|---|
| 1. Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> | 10. Current Manchester address:   |
| 2. Male <input type="checkbox"/> Female <input type="checkbox"/>  | _____   |
| 3. Surname _____  | _____   |
| 4. First names: _____   | _____   |
| 5. Previous surname(s): _____   | _____   |
| 6. Date of birth: Day/ Month / Year   |   |
| 7. NHS number (if known) _____  | 11. How long will you be at this address?   |
| 8. Town and Country of birth: _____   | Less than 6 months <input type="checkbox"/> More than 6 months <input type="checkbox"/> |
|   | 12. Home telephone: _____   |
| 9. If you are from abroad, the date you came to the UK _____  | 13. Work telephone: _____   |
|   | 14. Mobile telephone: _____   |
|   | 15. Email: _____  |

### Section 2 - Previous GP

16. Have you **ever** been registered with a GP in the UK? Yes  No
17. Name and Town of last GP/Surgery: \_\_\_\_\_
18. Your address while registered with previous GP: \_\_\_\_\_

### Section 3 - Your next of Kin/Emergency Contact

19. Next of kin's name: \_\_\_\_\_
20. Relationship to you: \_\_\_\_\_
21. Next of kin's address: \_\_\_\_\_
22. Telephone number: \_\_\_\_\_
23. Do you give consent for the practice to discuss your medical record with this person?  
Yes  No  Signature \_\_\_\_\_

### Section 4 - Your Ethnic Group

24. Please choose one of the five sections and then tick your ethnic group (Please tick one box only - These ethnic group descriptions are a national standard taken from the 2011 census)

#### White

- English/ Welsh/ Scottish/ Northern Irish/ British
- Irish
- Gypsy or Irish Traveller
- Any other white background
- Please state other \_\_\_\_\_

Any other mixed/ Multiple ethnic background

Please state other \_\_\_\_\_

#### Asian/ Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background
- Please state other \_\_\_\_\_

#### Mixed/ Multiple ethnic groups

- White and Black Caribbean
- White and Black Africa
- White and Asian



Please note that as a practice there are certain medications that we feel should not be prescribed on a long term basis. These are mostly a group of medications which are prescribed to aid sleeping, such as Zopiclone. **Please note that you will be expected to agree to a reduction process should you wish to be registered at the practice.**

### Section 9 - Lifestyle

31. Are you the main carer (unpaid) for someone who has poor health, or a disability? Yes  No

32. Do you smoke?  
Never smoked  Smoker  = Number of cigarettes per day \_\_\_\_\_ Ex-Smoker

33. Do you drink alcohol? Yes  No

If yes:

a. How often do you have a drink containing alcohol?

Monthly of less  2-4 times per month  2-3 times per week  4+ times per week

**Alcohol units: Pint of beer/ lager/ cider = 2, Single spirits (25ml) = 1 Glass of wine (175ml) = 2, Alcopop = 1.5**

b. How many units of alcohol do you drink on a typical day when you do drink?

1-4  5-7  8-9  10+

34. How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year?

1-4  5-7  8-9  10+

**If you are worried about your alcohol consumption please make an appointment to see your GP**

35. Height \_\_\_\_\_

36. Weight \_\_\_\_\_

37. Allergies \_\_\_\_\_

38. Smear (women and trans people with cervixes over the age of 25)

- Date of last smear test \_\_\_\_\_

- Result \_\_\_\_\_

- Place taken \_\_\_\_\_

- When smear next due \_\_\_\_\_

### Section 10 – Students – Over 16 only

39. Are you currently a full time/part time student aged 16 and over in Further education or University?

Yes  No

If yes have you received 2 doses of MMR vaccine? Yes  No

**If not please make an appointment with the Practice Nurse to receive the same**

### Section 11 – Complete this section for children under 16

#### 40. Childhood immunisations

Are you filling this form in for a child under 16? Yes  No

If yes is the child up to date with their immunisations? Yes  No

Did your child receive their immunisations in the UK? Yes  No

If yes please state which area \_\_\_\_\_

Did your child receive their immunisations abroad? Yes  No



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If yes please state which Country \_\_\_\_\_

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**Section 12 – Parents details**

41. Parental Employment Status

**Mother**      In full time employment       Part time employment       Unemployed       N/a

**Father**      In full time employment       Part time employment       Unemployed       N/a

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**Section 13 – Children aged 0-3 and a half years old**

42. During the day, your child is looked after by:

Parent       Relative       Friend       Nursery       Playgroup

**Name of day care provider** \_\_\_\_\_

**Contact number** \_\_\_\_\_

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**Section 14 – Children aged 3 and a half to 16 years old**

43. Is your child attending school?    Yes     No

If yes, name of school: \_\_\_\_\_      Contact number: \_\_\_\_\_

If no, please state the reason why: \_\_\_\_\_

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**Section 15 – Childcare arrangements**

44. Who looks after your child before and after school?

Name \_\_\_\_\_

Contact Number \_\_\_\_\_

Please circle which one of the following applies:

Parent      Relative      Friend    Nursery      Playgroup      before/after school club