**ST. MARY’S MEDICAL CENTRE – New Patient Questionnaire – Adult aged 16+**

Please complete as much of this form as possible to help us understand your current health and future health needs.

|  |  |
| --- | --- |
| First Name(s) |  |
| Surname |  |
| Date of birth |  |
| Home Telephone number |  |
| Mobile phone number |  |
| Next of kin name and contact number(ie who we should contact in an emergency) |  |
| Do you have any children living with you?If yes please list their names and dates of birth | Yes / No |
| Place / country of birth |  |
| What is your main spoken language |  |
| Will you require an interpreter for appointments? |  |
| What is your ethnicity(eg white British, black Caribbean, Pakistani etc.) |  |
| Are you a military veteran?If Yes do you consent to this being recorded in your medical records?If Yes which service (Army,Navy,RAF) | Yes / NoYes /No |
| If we need to contact you, what is your preferred method of contact? (eg text, mobile phone, letter) |  |
| Are you a carer? If so, for whom?(ie do you regularly look after someone who is ill, disabled or frail?) |  |
| Do you have a carer? If so, whom? |  |

**Smoking history:**

|  |  |
| --- | --- |
| Do you smoke?If yes, how many cigarettes per day? | Yes / No |
| Are you an ex-smoker?If yes, when did you stop smoking? | Yes / No |
| Would you like some information to help you give up smoking? | Yes / No |

**Alcohol:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 | 4 | Score |
| How often do you have a drink containing alcohol | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How many alcoholic drinks do you have on a typical drinking day | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 or more alcoholic drinks on one occasion | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**Your medical history:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Illness, accident, operation | Date | Illness, accident, operation |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Do you have any allergies?If yes, to what? | Yes / No |
| Are you currently under the care of a hospital doctor? If Yes, which doctor and where. | Yes / No |

**Your current medication**: Note that doctors may not prescribe the following – controlled drugs (eg methadone), sleeping tablets, strong painkillers, tranquillisers, Tramadol or codeine based products.

**\*Please bring proof of medication taken with you to your registration check\***

|  |  |
| --- | --- |
| Medicine name | Strength and dose |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Family History** – has any member of your immediate family (parents, brothers, sisters) suffered from any of the following:

|  |  |
| --- | --- |
| Heart disease | Who? |
| Diabetes | Who? |
| Stroke | Who? |
| High blood pressure | Who? |
| Cancer (specify which cancer) | Who? |

**Women only**

|  |  |
| --- | --- |
| Date of most recent cervical smear test |  |
| What was the result of that test? |  |
| Have you ever had an abnormal smear result? |  |
| Have you ever had a mammogram (breast xray)? If so, when? |  |
| Which form of contraception, if any, do you use? |  |

**PRACTICE USE ONLY**

**NEW PATIENT CHECK LIST**

**PATIENT PRESENTS WITH MEDICAL CARD**

Check in Practice Area [ ]

Name & Address [ ]

Signed and Dated [ ]

**REGISTRATION FORM (GMS1)**

 Check in Practice area [ ]

 Title, surname, Forename & previous surname(s) [ ]

 Date of Birth [ ]

 Town and Country of Birth [ ]

 Previous Address if recently moved [ ]

 Previous GP’s name and address [ ]

If child < 5 check if registering for Child Health [ ]

Check form signed and Dated [ ]

 Patient Access form completed (adults only) [ ]

**IDENTIFICATION REQUIRED – IDEALLY PHOTO ID**

Photo Driving Licence [ ]

 Passport [ ]

 Other (Bus Pass/Student Card [ ]

 Birth certificate [ ]

 Marriage Certificate [ ]

**PROOF OF ADDRESS**

 Recent Utility Bill [ ]

 Council Tax Bill [ ]

 Benefits Statement [ ]

 Other [ ]

 Details

**RECEPTIONIST SIGNATURE**