**New Patient Questionnaire: Adults aged over 18 years of age (To be completed with GMS1)**

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| **PERSONAL DETAILS** | | | | |
| **Name:**  **Preferred name(s):** | | | **NHS Number (if known):** | |
| **Email address** |  | | | |
| **Marital Status**  (*Please circle)* | Single Married Co-habiting Divorced Separated Widowed | | | |
| **Occupation:** |  | | | |
| **Religion**  (*Please circle)* | Christian Buddhist       Hindu Jewish Muslim Sikh  Any other religion, please describe:  Prefer not to say | | | |
| **Do you consider yourself to have a disability?**  *(Please Circle)* | No  Yes: Physical Sensory Learning Disability Mental Health  Other: | | | |
| **Ethnicity**  (*Please circle)* | **White**  British  Irish  Gypsy or Irish Traveller  Any other White background, please describe: | | | **Mixed/Multiple ethnic groups**  White and Black Caribbean  White and Black African  White and Asian  Any other Mixed/Multiple ethnic background, please describe: |
| **Asian/Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background, please describe: | | | **Black/ African/Caribbean/Black British**  African  Caribbean  Any other Black/African/Caribbean background, please describe: |
| **Other ethnic group**  Arab  Any other ethnic group, please describe:  Prefer not to say |
| **First language:** | | **Immigration status:** | | |

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| **COMMUNICATION REQUIREMENTS** | | |
| **Do you require any of the following:**  *(Please circle all that apply)* | I need an Interpreter  I use lip reading  I use textphone / Minicom | I need large print  I rely on British Sign Language  Other (please specify) |

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| **NEXT OF KIN / FAMILY DETAILS** | | | | | | |
| **Next of Kin** | **Name:** | | | **Contact Number:** | | **Relationship to you:** |
| **Do you have any caring responsibilities for children (under Age 18):** | | | Yes / No *(If yes please fill in section below)* | | | |
| **Child name:**  **Child DOB:**  **Child Address** *if different to yours:*  **Child GP Practice** *if different to yours* | | **Child name:**  **Child DOB:**  **Child Address** *if different to yours:*  **Child GP Practice** *if different to yours* | | | **Child name:**  **Child DOB:**  **Child Address** *if different to yours:*  **Child GP Practice** *if different to yours* | |

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| **MEDICAL HISTORY** | | | |
| **Personal medical history:** *(Please circle)*  Hearing problems  Vision Problem  Seizures in Childhood  Literacy Problems  Allergies  Hip Problems  Heart Conditions  Asthma  Diabetes  Contact with Tuberculosis  Infectious Diseases  Cancer  Mental Health  Other (Please specify) | **Any further comments:** | | |
| **Family medical history:**  *(Please circle and specify who in further comments)*  Hearing problems  Vision Problem  Seizures in Childhood  Literacy Problems  Allergies  Allergies to Medication  Hip Problems  Heart Conditions  Asthma  Diabetes  Contact with Tuberculosis  Infectious Diseases  Cancer  Mental Health  Other (Please specify) | **Any further comments:** | | |
| **Do you smoke?**  *(Please circle)* | Yes No  If so how many per day?  If you are an ex-smoker when did you stop? | **Do you use drugs?**  *(Please circle)* | Yes No |
| **Alcohol Consumption**  *Please add number of units per week – please see attached sheet* | \_\_\_\_ Units Per Week | | |

Are you a carer for anyone aged 18yrs and older? If so please give details -

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| **CURRENT MEDICATION** *(Please list including dosage instructions)* | |
| **Health Condition** | **Medication Required** |
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| **IMMUNISATION HISTORY** | |
| **Immunisation** | **Date Given** |
| BCG |  |
| 1st Diptheria/ Tetanus/ Pertussis/ Polio/ Hib  1st Pneumococcal  1st Rotavirus |  |
| 2nd Diptheria/Tetanus/Pertussis/Hib  1st Meningitis C  2nd Rotavirus |  |
| 3rd Diptheria/Tetanus/Pertussis/Hib  2nd Pnemococcal |  |
| Hib/Meningitis C  MMR 1  Pneumococcal booster |  |
| Diptheria/Tetanus/Polio/Pertussis booster |  |
| MMR 2 |  |
| HPV (Girls only) |  |
| Diptheria/Tetanus/Polio booster  Meningitis C booster |  |
| Other |  |