**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 HealthOther:  |
| **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 readingI use textphone / Minicom | I need large printI 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 problemsVision ProblemSeizures in ChildhoodLiteracy ProblemsAllergiesHip ProblemsHeart ConditionsAsthmaDiabetesContact with TuberculosisInfectious DiseasesCancerMental HealthOther (Please specify) | **Any further comments:** |
| **Family medical history:***(Please circle and specify who in further comments)*Hearing problemsVision ProblemSeizures in ChildhoodLiteracy ProblemsAllergiesAllergies to MedicationHip ProblemsHeart ConditionsAsthmaDiabetesContact with TuberculosisInfectious DiseasesCancerMental HealthOther (Please specify) | **Any further comments:** |
| **Do you smoke?***(Please circle)* | Yes NoIf 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/ Hib1st Pneumococcal1st Rotavirus |  |
| 2nd Diptheria/Tetanus/Pertussis/Hib1st Meningitis C2nd Rotavirus |  |
| 3rd Diptheria/Tetanus/Pertussis/Hib2nd Pnemococcal |  |
| Hib/Meningitis CMMR 1Pneumococcal booster |  |
| Diptheria/Tetanus/Polio/Pertussis booster |  |
| MMR 2 |  |
| HPV (Girls only) |  |
| Diptheria/Tetanus/Polio boosterMeningitis C booster |  |
| Other |  |