# Pitcairn Medical Practice
# New Patient Questionnaire

Date: ____/_______/____

***Areas are mandatory. Failure to complete may delay the time taken to process your registration***

***Surname**: ______________________

***Address**:

________________________________

________________________________

________________________________

Post Code: _____________________

***Forename**(s): ______________________

***Date of Birth**/CHI: ___________/_________

Marital Status: ______________________

Sex: Male / Female *(delete as applicable)*

Ethnic Group: ____________________

Occupation: _________________________

***Telephone Details**

Home: ______________________________

Work: ______________________________

Mobile: ______________________________

E-Mail: ______________________________

***Next of Kin**:

Name: ______________________________

Address: ____________________________

______________________________________

Tel No: ______________________________

Relationship: _________________________

*Do you give permission for the surgery to leave a phone message for you to make contact with the surgery? **YES / NO**

If you answered yes-which number would you prefer we used?

Home Work Mobile *(delete as applicable)*

Are you a Forces Veteran? **YES / NO**

## General History

Do you, or have you ***ever*** had, any serious illness or operations? **YES / NO** *(delete as applicable)*

If 'Yes' please enter the date for any major diagnosis, and if you are having on-going treatment.
*(If More Space Required Please use Pg 4)*

| Start date | Diagnosis | Treatment | Specialist |
|---|---|---|---|
| | | | |
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**General History Continued**

Are you currently taking any medication? **YES / NO** *(delete as applicable)*

*If Yes Please Enter Details Below – (If More Space Required Please use Pg 4)*

| Drug name | Drug Dose / Strength | Dose Interval (e.g four times a day, one at night | Reason for Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies**

Have You Any Allergies, or Had An Adverse Reaction To Any Medication? **YES / NO**

*If Yes Please Enter Details Below - If More Space Required Please use Pg 4*

| Date | What Are You Allergic To? | Nature of Adverse Reaction *if known* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Smoking:

Are You A Current Smoker? **YES / NO** If YES How Much Do You Smoke per Day? ____

Have You Ever Smoked? **YES / NO** If YES When Did You Stop ___/_____/___

Are You An Ex Smoker? **YES / NO** If YES How Many Per Day Did You Smoke? ___

How Many Years Did You Smoke? _____

## *Alcohol Intake: *(for patients aged 16 and over)*

***1 spirit measure = 1 unit***
***1 pint = 2-3 units***
***1 x bottle of wine = about 10 units***

What is your average weekly alcohol intake? ________units per week

***Caring :*** ***Excluding healthy children aged 16 and under***

Do You Look After Someone? **YES / NO** Does Someone Look After You? **YES / NO**

*If Yes to Either Please Enter Details Below*

Who Do You Look After / Looks After You and What Help Do They / You Need?

______________________________________________________________________

______________________________________________________________________

## Female Patients Only

Date of Last Smear: ___/_____/___

Have You Had Any Children? **YES / NO** If 'YES' What Ages? ______________

Have You Had A Miscarriage/Termination **YES / NO** If 'YES' What Date? ______________

Have You Had A Hysterectomy? **YES / NO** If 'YES' What Date? ______________

What Method of Contraception Are You Currently Using, If Any? ____________________________

## Family History

**Do you have any significant family medical history that you think we should be aware of: e.g Cancer or Cardiovascular Disease?** *(If More Space Required Please use Pg 4)*

| Condition | Relationship to you; e.g parent/sibling | Approximate Age They Were Affected |
|---|---|---|
| | | |
| | | |
| | | |

## Vaccinations:

Have you been fully vaccinated as a child? **YES / NO / NOT KNOWN**

**Would you like to book a new Patient Medical?** **YES* / NO**
*(If 'Yes' our Reception Team will contact you to arrange)*

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***PLEASE USE THIS SPACE FOR FURTHER INFORMATION***