**CALDERLEA SURGERY**

**NEW PATIENT QUESTIONNAIRE**

Complete this form as fully as possible using block capitals

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| **GENERAL INFORMATION** |

Mr/Master/Mrs/Miss/Ms/other please specify……………………………………………………

Full name: ……………………………………………………………………………………………...

Date of Birth: …………………………………………………………………………………………..

Home Telephone Number: …………………………………………………………………………

Mobile Telephone Number: ………………………………………………………………………..

Email Address: …………………………………………………………………………………………

(NB we may use your mobile number for appointment text reminders and send you other communication by SMS, by providing your number you consent to this. We may contact you in the future by email, by providing your email address you consent to this)

**What is your ethnic group?**

Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

**A White**

Scottish

English

Welsh

Northern Irish

British

Irish

Gypsy/Traveller

Polish

Any other white ethnic group, please state …………………………………………

**B Mixed or multiple ethnic groups**

Any mixed or multiple ethnic groups

**C Asian, Asian Scottish or Asian British**

Pakistani, Pakistani Scottish or Pakistani British

Indian, Indian Scottish or Indian British

Bangladeshi, Bangladeshi Scottish or Bangladeshi British

Chinese, Chinese Scottish or Chinese British

Other, please state ……………………………………………………………………….

**D African, Caribbean or Black**

African, African Scottish or African British

Caribbean, Caribbean Scottish or Caribbean British

Black, Black Scottish or Black British

Other, please state ……………………………………………………………………….

**E Other ethnic group**

Arab

Other, please state ……………………………………………………………………….

**If you do not wish to give this information, please tick here**

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| **NEXT OF KIN** |

Relationship to you…………………………………………………………………………………….

Mr/Master/Mrs/Miss/Ms/other please specify……………………………………………………

Full name: ………………………………………………………………………………………………

Address: ………………………………………………………………………………………………...

Home Telephone Number: …………………………………………………………………………

Mobile Telephone Number: ………………………………………………………………………..

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| **YOUR HEALTH** |

**Please circle what bests describes you**

Smoker Never Smoked Ex-Smoker

No. per day……………………………………………………………………………………………..

Currently drinks Lifelong Teetotaller Ex-Drinker

Units per weeks ………………………………………………………………………………………...

I Undertake Gentle exercise Moderate exercise Vigorous Exercise Inactive

My diet is Vegan Vegetarian

My eating habits are Good Moderate Poor Not examined

Height ………………………………….. Weight …………………………………………

**Are you a carer?** Yes/No if yes, who do you care for? ………………………………..

**Are you cared for?** Yes/No If yes, who cares for you? …………………………………….

**Do you need an interpreter or sign language support? Yes No**

If you need an interpreter what language do you speak? ………………………………

**Do you have any allergies or drug reactions?** ……………………………………………………………………………………….....

**FEMALE PATIENTS ONLY**

When was your last smear test? …………………………………………………………………...

When was your last mammogram? ………………………………………………………………

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| **YOUR MEDICAL HISTORY** |

Do you have any illnesses g. Heart disease, High Blood Pressure, Diabetes, Asthma, Epilepsy, Migraine, Stroke, Arthritis, Ulcer, Depression, Cancer

……………………………………………………………………………………………………………

What medication are you currently taking?

..…………………………………………………………………………………………