LADYWELL MEDICAL CENTRE (EAST)
PATIENT QUESTIONNAIRE – ADULT

How we use your information:

The information you have provided will be used by the GP Practice to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.
You will be issued with a Privacy Information Leaflet when you register. You can also find our full Privacy Notice on our website www.ladywelleast.co.uk or ask for a copy from Reception. Please contact the Practice Data Protection Officer if you have any queries.

If you would like a new patient health check please advise reception staff who will book you an appointment.

Registration

Have you been registered at this Practice before: Yes / No If yes, approximately when?

Personal Details

Full Name:	Date of Birth: / /
Address (inc postcode):	Tel Nos: Home: Work: Mobile:
Do you consent to receiving texts from the Practice in relation to appointments and your health to the mobile telephone number above: Yes / No (we can only text to UK mobile numbers)	
Marital Status: Single/Married/Separated/Divorced/Widow/Partner	Male / Female:
Emergency contact (name and telephone number):	
Are any family members living in the same house AND registered at this Practice (name and date of birth):	
Do you need an interpreter? Y / N	If yes, which language?

Medications

Please list regular medications taken, including over the counter remedies	
1.	5.
2.	6.
3.	7.
4.	8.

Your Health – Past and Present

Do you suffer from? (Please tick)	High blood pressure
Asthma or other chest complaint	Angina or other heart condition
Diabetes	Other (please state)
Other (please state)	Other (please state)

Have you had any serious illness or operations?	
What:	When:
What:	When:
What:	When:
Do you have a visual or hearing impairment Y / N	If yes, please state:
Do you have any allergies? Y / N	If yes, please state with as much detail as possible:

Healthy Living:

Smoking Status: (please circle) Current Y / N	Ex-Smoker Y / N Date Stopped:	Never Y / N
Do you drink alcohol? Y / N	If yes, how many units per week?	
Do you eat healthily? Y / N	Do you exercise regularly? Y / N	If yes, what?
Height:	Weight:	

Your family

Have any close family members (parents, children, brothers, sisters) had any of the following? Please tick and state which family member		
Angina:	Stroke:	Mental Illness:
Heart Attack:	Epilepsy:	Glaucoma:
Cancer:	High B.P.:	Asthma:
Diabetes:	Any other serious illness:	
Are you a carer? Y / N	If yes, is the patient registered at Ladywell Medical Centre East? Y / N	
What is the cared for person's name:		Date of birth: