# *NEWBYRES MEDICAL GROUP*

**New patient Questionnaire**

Have you been registered with us before? YES/NO

**Please complete all questions on both sides**

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

Date of birth: .........................................................................................................................................

Telephone Number: ..........................................................................................................................................

Mobile Number:

.........................................................................................................................................

Marital status: ........................................................................................................................................

Emergency telephone contact number: ........................................................................................................................................

Ethnic origin:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Scottish |  |  | |  | Polish |  |  | |  | Other Asian Ethnic Group | | | |
| English |  |  | |  | Other Ethnic Group | | | |  | Black African | | |  |
| Welsh |  |  | |  | Other mixed Ethnic Group | | | |  | Black Caribbean | | |  |
| Northern Irish | |  | |  | Pakistani |  |  | |  | Black British | |  |  |
| British |  |  | |  | Indian |  |  | |  | Other Black Ethnic Group | | | |
| Irish |  |  | |  | Bangladeshi |  |  | |  |  | |  |  |
| Traveller |  |  | |  | Chinese |  |  | |  |  | |  |  |
|  |  |  | |  |  |  |  | |  |  | |  |  |
|  | | |  | | | | |  | | |

Do you need an interpreter? YES/NO

If YES which language?

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Are you a Carer? YES/NO Do you have a Carer? YES/NO

If yes please provide details of your Carer

Name:

........................................................................................................................................

Address:

........................................................................................................................................ (Please note this is not mandatory)

Height: ........................................................................................................................................

Weight: ......................................................................................................................................

Are you registered disabled? Yes/No

Are you housebound? Yes/No

Do you have any allergies? Yes/No

If yes please give details:

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Smoking Status - please circle one:

Never Smoked/ Ex Smoker/E-Cigarette /Current Smoker - how many do you smoke per day?

Do you drink alcohol? YES/NO If YES how many units per week?

Family History – Have you or any of your relatives (parents, brother, sister) been diagnosed with any of the following?

Self Mother Father Sister Brother

Diabetes 🞏 🞏 🞏 🞏 🞏

Cancer 🞏 🞏 🞏 🞏 🞏

Asthma 🞏 🞏 🞏 🞏 🞏

Stroke 🞏 🞏 🞏 🞏 🞏

Heart Attack 🞏 🞏 🞏 🞏 🞏

High Blood pressure 🞏 🞏 🞏 🞏 🞏

Thyroid disorder 🞏 🞏 🞏 🞏 🞏

High Cholesterol 🞏 🞏 🞏 🞏 🞏

**Current Medications**

Please list below any medications you take regularly, either prescribed by a GP/Hospital/Clinic or bought at a pharmacy.

|  |  |  |
| --- | --- | --- |
| Medication | Dose | How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medical History** – Please give details of any past operations, major illnesses or serious medical conditions. Also list any ongoing conditions.

|  |  |  |
| --- | --- | --- |
| Date | Operation/Illness/Condition | Comments |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Sharing Your Contact Details**

Please help us to keep our records up to date by providing us with details of your mobile number if it changes.

We may send text reminders for appointments or information about the practice, such as being closed on a public holiday. You may withdraw consent to this at any time by contacting reception.

In addition to this, we may send text messages that contain clinical information such as results or review reminders, do you give consent to this? (You may withdraw consent to this at any time by contacting reception.)

Yes 🞏

No 🞏

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment given for new patient medical? Yes No

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**To be completed by the practice nurse**

Date of medical:

Height:

Weight:

BP:

Urine:

Smoking Cessation offered

Alcohol units per week

Drug Allergies: