New Patient Questionnaire (confidential)

Welcome to **The Practice**. It may take several weeks for the records to reach us from your previous GP. Answering these questions will help us to provide good medical care for you during this time. Please complete all sections:

Applicant Details			
Title: Mr/Mrs/Miss/Ms/Other			
Name:			
Address:			
Postcode:			
Tel. No (Home):			
Work/School No:			
***Mobile:**			
Email:			
Occupation/School:			
Gender:	**Male / Female**	**Date of Birth:**	
Marital Status:		**Height:**	**Weight:**

Applicant's Parent/Guardian Details	
Title: Mr/Mrs/Miss/Ms/Other	
Name:	
Address:	
Postcode:	
Occupation/School:	
Tel. No (Home):	
Work/School No:	
Mobile:	
Date of Birth:	
Email:	

Applicant's Next of Kin Details			
CURRENT Next of Kin Name: (Note: any previous next of kin details will be removed from your records)		**Contact No:**	
Relationship to me:		**Email:**	
Address:			
No Next of Kin: Please remove details of any previous Next of Kin YES / NO			

Medical History - Please tick the boxes below to indicate whether you have had any of the following:

☐ Asthma	☐ Kidney Disease NOS	☐ Heart Disease	☐ Transient Ischaemic Attack
☐ Hypothyroidism	☐ Stroke NOS	☐ Cancer	☐ Diabetes
☐ Epilepsy	☐ Mental Health Disorder	☐ Essential Hypertension	

Please give details of any other significant illness or surgical operation:

Medication Drugs - Please list ALL medication you take (including the contraceptive pill) and any over the counter purchases from the chemist:

Allergies - Please give details of any known allergies (medicines, food, insect bites):

Female Patients Only:

Please give date and result of your last cervical smear (if applicable)**:**	Do you have a contraceptive coil fitted? If so, please confirm month/year of fitting:

15-24 Year Olds Only: We are offering a urine test for Chlamydia, a sexually transmitted infection. Would you like this?	**Yes / No**

Form continues on reverse, please turn over.

Summary Care Record - The summary care record is an electronic summary of basic information such as allergies and regular medicines. In an emergency situation, doctors and nurses working in A & E, NHS 111 or Out of Hours will have secure access to any allergies you may have and details of your regular medication. This will enable them to make the best informed care decisions based on this information. You will have been notified previously about the SCR in the post. **Please note that you will have automatically been opted in to have a Summary Care Record unless you completed a form, when notified, to opt-out.** For your information, very few patients opt out of having a Summary Care Record. We will assume you have opted in for a SCR unless you inform us differently below:

Family History - Please tick the boxes below to indicate whether or not any of your immediate family have ever suffered from any of the following and if yes, who. If 'yes' please indicate family member & age diagnosed.

High Blood Pressure	☐	
Epilepsy	☐	
Mental Illness	☐	
Diabetes	☐	
Asthma	☐	
Stroke	☐	
Heart Disease	☐	
Cancer (specify)	☐	

Any other significant inherited problems:

Do you have any disabilities?	**Yes / No**	**If Yes, please give details:**	

Smoking - Please tick a box below to indicate whether you have ever smoked (Over 15 only)

☐ Currently Smoke	☐ Ex-Smoker	☐ Never Smoked	☐ Trying to give up
☐ Smoking Cessation	☐ Wants to stop	☐ Not interested in stopping	

If you smoke, how many per day?		**If you have given up smoking, when did you do so?**	

Alcohol Consumption - (1 pint beer = 2 units, 1 small glass of wine = 1 unit, 1 single short = 1 unit)

How many units of alcohol do you drink in an average week?		☐ Tick this box if you do not drink alcohol.

Are you in the Armed Forces?	**Yes / No**	**Are you a veteran of the Armed Forces?**	**Yes / No**

Carer Status - Are you caring for someone or does someone care for you? A carer is a person who is looking after, or is responsible for, the care of a relative, friend or neighbour whose health is impaired by old age, or who is mentally or physically disabled.

My Carer is:		**I care for:**	
Name:		**Name:**	
Address:		**Address:**	
Postcode:		**Postcode:**	
Tel. No (Home):		**Tel. No (Home):**	
Relationship to me:		**Relationship to me:**	

Ethnicity - The Department of Health asks us to monitor the ethnicity of our patients. Please tick below:

☐ White – British	☐ Mixed – Asian/White	☐ Indian
☐ White – Irish	☐ Mixed – any other	☐ Pakistani
☐ White – other white	☐ Black - African	☐ Bangladeshi
☐ Mixed – black Caribbean/White	☐ Black - Caribbean	☐ Asian – other
☐ Mixed – Black African/White	☐ Black - other	☐ Chinese

Are you an English speaker?	**Yes / No**	**Do you require a translator?**	**Yes / No**
What is your first language?			

☐ **Please tick this box if you are happy for us to contact you by mobile for appointment reminders**

Thank you for answering this questionnaire! It will greatly help us to look after you and your family.