**NEW PATIENT QUESTIONNAIRE - IT IS IMPORTANT TO COMPLETE ALL SECTIONS**

Full name …….. Date of Birth ……

Address……

Postcode…… NHS Number (if known) ……. Marital Status S/M/W/Other

Contact Numbers: Home…… Mobile…..... Work ……..

Email address: **(Please Print)** Religion ……..……

Which country were you born in? …… If not English, main spoken language……..

Do you give us permission to contact you via your mobile if we need to? Yes / No
Do you give us permission to contact you via email if we need to? Yes / No

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Do you smoke? Y/N If yes, how many a day…….…….. What age did you start smoking ……

Ex- smokers: Year stopped……... How many did you smoke a day? ……

How often do you have a drink that contains alcohol: *Never* *Monthly or less* *2-4 times per month*
*2-3 times per week* *4+ times per week*

How many standard alcoholic drinks do you have on a typical day when you are drinking?
*1- 2* *3-4* *5-6* *7-8* *10+*

How often do you have 6 or more alcoholic drinks on one occasion?
*Never* *Less than monthly* *Monthly* *Weekly* *Daily or almost daily*

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**CURRENT MEDICATION** ***(ie Paracetamol 500mg, one per day, back pain)***

1. Name & strength: …… Dosage per day ……
   Why do you take this medication ……Year diagnosed ……
2. Name & strength: …… Dosage per day ……..
   Why do you take this medication …… Year diagnosed ……
3. Name & strength: …… Dosage per day ……..
   Why do you take this medication …… Year diagnosed ……
4. Name & strength: …… Dosage per day ……..
   Why do you take this medication …… Year diagnosed

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**HAVE YOU EVER HAD SIDE EFFECTS FROM ANY MEDICATION?**

Name & strength: …… Side effect ……

Name & strength: …… Side effect ……

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**OTHER IMPORTANT ILLNESSES/OPERATIONS/ACCIDENTS (continue overleaf if necessary)**

Year …….…….. Description …….

Year ……... Description …….

Year …….….. Description …….

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| **FAMILY HISTORY** | **If alive, serious illnesses** | **If dead, cause of death and age when died** |
|---|---|---|
| Father | …… | ……..… |
| Mother | …….. | ……. |
| Brothers | …….. | ……..…… |
| Sisters | …… | ……. |

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**PLEASE TURN OVER >**

**EMERGENCY CONTACT PERSON**

NAME …… RELATIONSHIP ……

ADDRESS ……POST CODE ……

CONTACT TELEPHONE NO. ……

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**CARERS**

Do you look after someone who is frail, elderly, disabled or mentally ill? YES ☐ NO ☐

Do you have a carer who looks after you? YES ☐ NO ☐

If so, please give the details of that person below.

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Have you ever served in any of the armed services **(Xa8Da)** YES ☐ NO ☐

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NHS England have said that from 2015, every patient has to have a 'named' GP who is responsible for their care recorded on their records.

This is a paper exercise only and it makes no difference whatsoever to the care you receive from the surgery and you are still able to see whichever doctor you wish or who is on duty.

**Please 'tick' which doctor you would like as your named GP: Dr Saul Miller** ☐

**Dr Clare Bromly** ☐

**SHARING YOUR RECORDS WITH OTHER USERS WHO YOU MIGHT SEE**

If you are referred by the doctors to other users who use the same clinical system as ours, SystmOne, they are able to access your records but only if you give permission. Other users would be, district nurses, health visitor, physiotherapist, podiatrist (chiropodist). As with everyone who has access to your records in the surgery, they are only allowed to access those parts of your record which are relevant to what you are being treated for under Access to Records and the Data Protection Act.

**Please tick as appropriate:**

I agree to sharing of my clinical record with other users who may need access for treatment purposes ☐

I do not agree to sharing of my clinical record with other users who may need access for treatment purposes ☐

***For completion by the doctor or nurse***

HEIGHT /m BP /

WEIGHT /kg URINE

**HEALTH CHECKS FOR 40 – 74 YEAR OLDS:**

WAIST CIRCUMFERENCE /cm

FH 1ST DEGREE RELATIVE WITH CARDIOVASCULAR DISEASE Y / N (if yes, who and age)

EXERCISE NONE / UNABLE / LIGHT / MODERATE / HEAVY

BLOOD: UE's, RBS, CHOLESTEROL, LFT, TFT