

Date (surgery to add):



New Patient Questionnaire

Please complete the details below. This gives us details about your medical history while we wait for your medical records to be sent from your previous doctor. All information provided will remain confidential.

PERSONAL DETAILS(Please Complete)

Mr/Mrs/Miss	Surname	Forenames
Date of Birth	Place of Birth	Occupation
Address		Postcode
Telephone (home)	Telephone (work)	
Mobile	Email Address	

ETHNICITY (Please circle)

White	British	Irish	Other:
Asian or British Asian	Indian	Pakistani	Bangladeshi Other:
Black or Black British	Caribbean	African	Other:
Other Ethnic group	Chinese	Japanese	Other:
Mixed background	Please specify:		
Is English your first language? Yes No	If No please state:		
Asylum seeker? Yes No	Refugee? Yes No		

NEXT OF KIN DETAILS (Please complete)

Name	Relationship
Contact No.	Address

CARER DETAILS (Please circle)

Are you a carer? Yes No This does not include being a parent	Who do you care for? Parent child friend Other:
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GENERAL HISTORY (Please complete)

Have you or your family had any of the following?

Disease or illness	Which relative
Asthma	
Cancer	
Diabetes	
Epilepsy	
Heart Attack	
High Blood Pressure	
Mental illness	
Stroke	

Have you had any serious illness, operations? (Please complete)

Date	Details

What medicines are you taking? (Please complete)

Drug Name	Strength	Number per day

Have you ever used drugs or solvents? (Please circle) **Yes No**
 If yes, please provide details

Do you have any allergies? **Yes No**
 If yes, please provide details:

SMOKING STATUS *Specify amount per day

Current Smoker*	Non-smoker	Ex-smoker*	Stopped Smoking*
Cigarettes Cigars Pipe (Oz)			Date:

VACCINATIONS

What vaccinations have you had? Please give details:

Diphtheria Tetanus Pertussis	Measles/mumps/ Rubella	Hepatitis A Hepatitis B	Meningitis C	Yellow Fever
Hib	Cholera	Rabies	Polio	Typhoid

WOMEN ONLY (Please complete)

How many pregnancies have you had?	Year	Sex	Birth weight

Have you ever had a miscarriage? **Yes No**

Have you had a hysterectomy? **Yes No**

Have you had a termination of pregnancy? **Yes No**

Have you had a cervical smear? **Yes No**
 If yes please give date: _____ and result: **Normal Abnormal Don't know**

ROUTINE HEALTH CHECK (Surgery to complete)

Height	Weight
Waist Circumference	BMI
Blood Pressure	Urine Protein Glucose