NEW PATIENT QUESTIONNAIRE

Welcome to the practice. Please ensure that you have collected a copy of the Practice Information Booklet, which will give you details of the services that we offer.

It can take several weeks for your medical records to reach us via the various administrative channels and we would therefore be grateful if you would complete this brief questionnaire (one for each member of the family) so that we can have at least the essentials of your health record.

We encourage new patients to attend for a free health check with one of the Practice Nurses. This only takes about 15 minutes and includes measurements of your height; weight and blood pressure, together with a urine test (please bring a specimen with you when you attend). These simple tests can yield very important and useful information, and many patients have found these visits to be a useful introduction to the practice.

If you have young children, particularly those under 5 years, one of our Health Visitors will make contact with you and ensure that the necessary checks and vaccines can be arranged

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:							
	☐ Tetanus				☐ Pneumonia		
	☐ Influenza				☐ MMR *Measles, Mumps, Rubella*	1st	2nd
	☐ Meningitis	1st	2nd	3rd	☐ Pre-school booster		
	☐ Triple and Polio	1st	2nd	3rd			
	☐ Hib	1st	2nd	3rd			

Do you have or have you been diagnose with any of the following:

High Blood Pressure ☐ Stroke☐ Heart Attack ☐ Diabetes ☐ Angina ☐ Asthma ☐

Any operations

Year	Reason	Hospital

Other significant illnesses

Year	detail

Allergies

Allergic to	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Alcohol	Pint of regular beer/larger/cider = 2 units	Alcopop or can of larger = 1.5 units	Glass of wine (175ml) = 2 units	Single measure of spirits = 1 unit	Bottle of wine = 9 units
	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 standard drinks on one occasion?				
	☐ Never	☐ Less than Monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

Smoking	Do you Smoke?	☐ Yes	☐ Never smoked	☐ Ex-smoker – please state the year you quit?	
	If you are a smoker, would you like help and advice on giving up?			☐ Yes	☐ No
Personal Safety	Are you a carer or do you have a carer? If yes download or contact the surgery for a carers registration form			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

Please indicate if any of the following family members have a history of:- Heart attack or angina under - 60 years, Stroke, Diabetes Mellitus or any other significant health problem

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Brothers & Sisters	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

ETHNICITY

☐ White	☐ Other ethnic group, please specify:	☐ No comment

WOMEN ONLY

Have you had a cervical smear test?						☐ Yes	☐ No
If yes	Date of last test:	Was it normal?	☐	Yes	☐	No	Where was the test done?
Have you had a hysterectomy?						☐ Yes	☐ No
If yes	Date of hysterectomy:						