New Patient Questionnaire

Please complete the form below fully to ensure correct registration
For further details or questions please ask staff

Personal Details

Title: First Names: Surname:	Date of birth: Male / Female: NHS No:

Home address: Postcode:

Home Tel: Mobile No: Email:

Can we send you SMS text messages regarding appointments or results: Yes / No

Employment status: Marital Status:

Previous GP Name / Surgery: Address: Postcode:

Previous Home address: Postcode:

Nationality: Country of Birth: First Language:

When did you arrive in the UK? (For patients from overseas)

Ethnic Origin

Please circle where relevant

White: British or Mixed British / Irish / Any other White (e.g. any European nationality, White Commonwealth etc.), please specify:
Mixed: White + Black Caribbean / White + Black African / White and Asian / Any other mixed background, please specify:
Asian / Asian British: Indian / Pakistani / Bangladeshi / Any other Asian background, please specify:
Black / Black British: Caribbean / African / any other Black background, please specify:
Other Ethnic Groups: Chinese / Any other ethnic group, please specify:
Not Stated: I do not wish to disclose

Alcohol

How often do you have a drink that contains alcohol?	N/A	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?	N/A	1-2	3-4	5-6	7-9	10+
How often during the past year have you found you were not able to stop drinking once you had started?	N/A	Never	Less than monthly	Monthly	Weekly	
How often during the past year have you failed to do what was normally expected of you because of drinking?	N/A	Never	Less than monthly	Monthly	Weekly	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	N/A	No	Yes, but not in the past year	Yes, during the past year		

Smoking			
Do you smoke? Yes / No / Not any more If Yes, what do you smoke: Cigarettes / Cigars / Pipe How many a day? If Not any more, when did you stop?			
Medical History			
Height: Weight:			
Significant Family History: (e.g. High blood pressure / Heart disease / Stroke / Cancer / Mental Illness), please specify			
Significant Past and Present Illness, please specify:			
Please list current medication (including dosage and frequency):			
Do you take regular exercise? Unable to / Never / Occasionally / Light exercise / Moderate / Regular			
Allergies			
Medication	Yes	No	Details
Other	Yes	No	Details
Vaccinations			
When did you last have a tetanus vaccination?			
Are you Rubella Immune? Yes / No	Date of Rubella vaccination		
Contraception			
Do you use contraception? Yes / No If Yes give details			
Female Patients Only			
Are you pregnant? Yes / No When did you last have a cervical smear? Was the result negative? Yes / No Is there a history of Breast / Ovarian Cancer in your family? Yes / No			

Additional Information: Please add anything else you think would be useful for the surgery to know:

Thank you for taking the time to fill out this questionnaire. This information is recorded in your computerised medical record. This will help us to plan any care that may be needed now or in the future.