Have you had any recent tests? Yes/No

If Yes please give details (blood, urine, x-ray, etc)

……..

Are you currently under the care of the hospital, on a waiting list or attending the out-patients (please give details)

……..

……..

Have you ever had a Health Promotion Check or a Full Medical? Yes/No

Have you ever served in the British Armed Forces? Yes/No

If Yes please indicate the results ……

……..

Is there anything else you would like the Doctor to know? ……

……

For completion by Female patients:

1. Do you have any problems at present? …….
2. Have you had a cervical smear Yes/No Date of last smear …….
3. Have you had a mammogram Yes/No Date of last mammogram ……..
4. Have you had a hysterectomy Yes/No If Yes please give details ……..
5. Contraceptive history (please indicate which type)

   Oral contraceptive Yes/No …….

   Coil Yes/No …….

   Cap/Diaphragm Yes/No ……
6. Would you like the Practice to provide Family Planning Services Yes/No

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For Nurse to complete

Urine …… Blood Pressure ……

Height …… Weight ……. BMI ……

Comments ……...

……..

Date …… Nurse ……...

(Form LS April 08)

15yrs and Over

The Park Surgery

116 King's Road, Herne Bay, CT6 5RE. Tel: 01227 742568 Fax: 01227 742277

The Herne & Broomfield Surgery

38 Broomfield Road, Broomfield, Herne Bay CT6 7LY. Tel: 01227 749678 Fax 01227 370638

NEW PATIENT REGISTRATIONS

This questionnaire is specifically designed for patients joining the Practice for the first time.

PLEASE ENSURE THIS SECTION IS FULLY COMPLETED

Title (Mr/Mrs/Miss/Ms) ……. Sex M/F Marital Status …….. Date of Birth ……..

Surname …… Forenames ……..

Address ……

……Post Code ……

Telephone numbers (home) ……(work) ……(mobile) ……..
Are you happy for us to leave a message on any of these numbers? ……
Are you happy to receive text messages from the surgery? Yes/No (For info—these will not contain any identifiable patient details)

E-mail address ……..

Occupation ……...

Next of kin and contact number……...

Name and address of previous GP ……

……

Place of birth ……...

HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS PRACTICE - YES / NO

Language

First Language Spoken …….. Second Language Spoken ……

Ethnic Origin - please tick appropriate box

White ☐ British ☐ Irish ☐ Other Background

Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani

Black or Black British ☐ African ☐ Caribbean ☐ Other Background

Mixed ☐ Other Background ☐ White and Asian ☐ White and Black African ☐ White and Black Caribbean

Other ☐ Chinese ☐ Other, please state …….

For staff use only

☐ Patient notices checked

Medical History

Do you have any mobility problems Yes / No ……..

……..

Do you have any medical history of any of the following, if Yes please give brief details

1. Ear, nose & throat problems Yes / No …….

   ……..

2. Eye problems Yes/No ……..

   ……...

3. Heart problems Yes / No ……..
   (including hypertension, heart attack, angina, stroke, etc.)

   ……...

4. Diabetes Yes/No ……..

   ……

5. Thyroid or Glandular problems Yes/No ……..

   ……...

6. Epilepsy Yes/No ……..

   ……...

7. Nervous / Psychiatric problems Yes/No
   (including depression, anxiety, dizzy turns, fainting attacks, etc)…….

   ……

8. Chest problems Yes/No
   (including asthma, bronchitis, TB, tumour, etc) ……..

   ……..

9. Skin problems Yes/No ……

   ……..

10. Know allergies Yes/No
    (including reactions to medication, antibiotics, hay fever, pollen, food allergens eg nuts, etc)……..

    ……

11. Any previous operations Yes/No ……..

    ……..

12. Other problems Yes/No ……..
    (not mentioned above)
    ……..

    ……..

    ……

Family History

Have any of your relatives suffered from any of the following. Please give details.

Stroke Yes/No ……

Heart disease Yes/No ……

Blood pressure Yes/No ……

Diabetes Yes/No ……

Cancer Yes/No ……..

Any other family history of note ……

Smoking

Have you ever smoked Yes/No

Do you smoke now? Yes/No

If Yes how many per day ……. How long have you smoked ……yrs

If No date gave up ……...

Would you like advice on stopping smoking Yes/No

Alcohol Do you drink alcohol? Yes/No

If Yes how often do you have a drink that contains alcohol

☐Monthly or less ☐2 - 3 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 - 9 ☐10+

How often do you have 6 or more standard drinks on one occasion

☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily

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Vaccinations

Tetanus Booster Yes/No (date) ……☐

Flu vaccination Yes/No (date) ……

Pneumovax Yes/No (date) ……..

Medication

Are you at present on any medication? Yes/No (If Yes, please attach a copy of your repeat medication slip from your previous surgery) ……...

Do you take Aspirin Yes/ No

Would you like to nominate a pharmacy to collect your prescription from? Yes/No (If yes, please give pharmacy details ……..