NEW PATIENT GENERAL HEALTH QUESTIONNAIRE

Personal Details:

Full name: …………………………….. Date of birth: …/…/… Sex: M / F

Address:

……….

Tel number: …………………..Mobile number: ………………………. Email address: ………………………………………..

Are you happy for us to send you textual reminders (please circle): Yes/No

Marital status (please circle): Married/Single/Widowed/Divorced/Separated

Occupation: ……………………………………….. **Armed Forces:** Yes/No **Year from** …./…. **Year to** …./….

Signed: ……………………………..

Next of Kin: Name: …………………………. Address: ……………………………………………………………………

Telephone number: ……………………………

Please inform us of any changes as soon as possible in order for us to update your records so that we are able to contact you regarding appointments or health reminders.

Carer information: If you are a carer we are able to register you on our clinical system to allow you additional support. Please ask at the reception desk for more details.

Accessible Information Standard: If you have a disability or sensory loss and would like to receive information and communications from us in a format which is clearer and easier to use (e.g. large print, braille or via email or require professional support e.g. British Sign Language interpreter), please tell us here:

………

………

Ethnicity: The health authority request that we record patient ethnicity on medical records. Please tick below the statement which best describes your ethnicity. Please tick ‘not stated’ to withhold this information.

910	British(White)	916	Any other mixed background	91C	African

91 1	Irish(White)	91 7	Indian or British Indian	91 D	Any other black background
91 2	Any other white background	91 8	Pakistani or British Pakistani	91 E	Chinese
91 3	Mixed White & Black Caribbean	91 9	Bangladeshi or British Bangladeshi	91 F	Any other ethnic group
91 4	Mixed White & Black African	91 A	Any other Asian background	91 G	Not stated
91 5	Mixed White & Asian	91 B	Caribbean		

Main language spoken: ………………………. **English speaker:** Yes /No

Gender: Male / Female **Religion:**……………………..

Hetrosexual	
Bisexual	
Homosexual	
Lesbian	
Transsexual	
Not stated	

Allergies: Do you have any known allergies: Yes / No

Details of allergies:

……………………………………………………………

Current Medication: Are you taking any regular medication from your doctor? : Yes / No

What date is your next prescription due? …./…./…. Please attach your repeat prescription from your previous GP. If you do not have a repeat form please list current medications below:

MEDICATION NAME	DOSE	FREQUENCY

Females only: It is important to give details of your oral contraceptive medication.

Method of contraception: …………………………….. **Current oral contraceptive medication:** …………………………

Past Medical History: Please list any major illness and / or surgical procedures that you have had:

Illness / surgical procedure	Date:

Family health: Have any of your family/close relatives had any of the following: (if yes, please give brief details)

	Yes / No	Details:
Stroke		
Heart Attack		
Diabetes		
Asthma		

Smoking: Do you smoke? **Yes / No** If yes how many per day? ☐

Alcohol: Do you drink alcohol? **Yes / No** If yes how many units do you drink per week?

BMI: What is your height? ……………Cms/inches What is your weight? ……………..Lbs/kg ☐

Females only: How many children do you have? Children's ages? …. …. …. ….

Any miscarriages/still births (please give details)

…………………………………………………………………………………………

Public Health:

Date of last:	**Rubella (German Measles)injection**	
	Last smear test	
	Mammogram (Breast x-ray)	

PLEASE NOTE:

It can take up to eight weeks for your medical records to be transferred to us from your previous surgery. In order for us to have as much information as possible before seeing a doctor we strongly recommend that you book a **10 minute New Patient Check appointment** with our Health Care Assistant. During this appointment the following will be checked:

- Blood Pressure
- Urine. A sample bottle will be given to you when making the appointment
- Weight (BMI)
- Current medications. You will not be able to request any repeat medication during this appointment