9 ALLOWAY PLACE
NEW PATIENT QUESTIONNAIRE

WELCOME TO OUR PRACTICE. WE WOULD BE GRATEFUL IF YOU WOULD COMPLETE THIS FORM. THIS WILL PROVIDE US WITH THE INFORMATION WE NEED UNTIL WE RECEIVE YOUR MEDICAL RECORDS.

WE WOULD ALSO REQUEST THAT YOU MAKE AN APPOINTMENT FOR A NEW PATIENT HEALTH CHECK. THANK YOU.

Title			
Full Name			
Known As			
Address			
Telephone		Mobile	
Relationship Status:			
Status:	Male □ Female □ Gender Identity ……..		
Name and address of previous GP			
If coming from abroad, UK entry date:			

Next of Kin Details:

ILLNESSES, ACCIDENTS OR OPERATIONS	
Please list all significant illnesses, accidents or operations with dates. Please also list any medical problems which you have at present.	

MEDICATION			
Please list any medicines or tablets you are taking at present. If you take psychotropic medication, we may need to contact your previous GP before registration.			
Name	Strength	Dosage	Reason for taking

ALLERGIES
Do you have allergies to medicines, food or animals Yes/ No If yes, please list below

SMOKING			
Do you smoke now?	Yes/ No	If Yes, how many per day?	
If you have smoked in the past, when did you stop?			

ALCOHOL	
How much alcohol do you drink per week (on average)?	

EXERCISE	
How much exercise do you take per week (on average)?	None/ mild/ moderate/ vigorous

HEIGHT AND WEIGHT			
What is your height?		What is your weight?	

OCCUPATION	
What is your occupation?	
What other jobs have you done in the past?	

FAMILY HISTORY			
Do you, or any of your close relatives have any of the following illnesses or conditions?			
Condition	**Yes**	**No**	**Details and family member**
Diabetes			
High Blood Pressure			
Heart Attack			
Stroke			
Inherited Diseases			
Cancer			
Kidney Disease			
Other diseases			
Are your parents still alive and in good health?			Mother: Father:
If either has died, could you please say how old they were when they died and what the cause of death was:			
	Yes	**No**	
Do you have any brothers and/ or sisters?			
Please list what ages they are and any serious illness they have suffered:			

WHAT IS YOUR ETHNIC ORIGIN?
We are obliged by law to ask the following questions. If you are happy to answer please do so below:
Please tick the relevant box: A. white – Scottish [ ] English [ ] Welsh [ ] Irish [ ] Gypsy/ traveller [ ] Polish [ ] Other white background, please specify…… B. Mixed. Any mixed background, please specify…….. C. Asian, Asian Scottish or Asian British – Indian [ ] Pakistani [ ] Bangladeshi [ ] Chinese [ ] Other Asian background, please specify……. D. Black, Black Scottish or Black British – Caribbean [ ] African [ ] Other Black background, please specify…….. E. Arab [ ] Other [ ] **Do require an interpreter** Yes/ No **Sign language needed** BSL [ ] Makaton [ ]

CARERS		
Are you a carer?	Yes	No
If yes, would you like to be referred to the Princes Trust for Carers who may be able to provide support and help? Yes/ No, I'm already know to them		

WOMEN ONLY		
CONTRACEPTION		
Do you use the Contraceptive pill, coil, depot injection or Implants?	Yes – if yes, for how long	No
What was the date of your last smear?		
PREGNANCY		
Please list all your children below:		
Name	**Date of Birth**	**Any problems with pregnancy or birth?**

Please add any further information you feel may be relevant:

Signed:_____

Date:_____

Thank you for completing this questionnaire.