Blackburn Road Medical Centre
Blackburn Road
Birstall
Batley
WF17 9PL

NEW PATIENT QUESTIONNAIRE

1. PERSONAL DETAILS

Surname……. First Names(s)……..

Date of Birth……. Place of Birth…….

Please circle
Gender: Male (including trans men) / Female (including trans women) /

Non-binary / In Another Way (Please Specify)
_____

Is this the gender you were assigned at birth? Yes / No

Sexual Orientation: Lesbian or Gay / Straight or Heterosexual / Bisexual /

Other (please specify)……

Marital Status……..

Address……

Home Telephone……. Mobile……

Email Address……

Occupation…… First Language……..

Ethnicity?.....

Please state your preferred method of contact (please ti…) Home ☐ Mobile ☐ Email ☐ Or any of the abov…

We want to get better at communicating with our patients. We would like to ensure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know if you have any
Special Communication Needs? E.g. BSL interpreter for hearing impairment or large print/braille or you lip read or use a hearing aid or communication tool.

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2. PERSONAL MEDICAL HISTORY

Have you ever suffered from any of the following?

Epilepsy Yes/No High Blood Pressure Yes/No

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Glaucoma Yes/No Cancer Yes/No
Where…….
Diabetes Yes/No Heart Attack or Angina Yes/No
When……..
Strokes Yes/No Asthma Yes/No
Mental Health Problems Yes/No

Please give details of any other serious illness or any time you have stayed in hospital including dates where possible:-

DATE	PROBLEM

3. MEDICINES

Are you taking any drugs or medicines? Yes/No
Please tell us the names and dose and how often you take the medicines.
NB You **must** make an appointment to see the Doctor before we issue you with a repeat prescription.

Do you have a nominated pharmacy, if so what is the name _____

WE RESERVE THE RIGHT TO RECONSIDER PRESCRIBING ANY OF YOUR EXISTING MEDICATION AT A FIRST CONSULTATION.

PLEASE TURN OVER

4. ALLERGIES

Are you allergic to any medications? Yes/No

If so, which ones?..... What happens if you take them?.....

5. TOBACCO & ALCOHOL

Are you a current smoker Yes/No If yes how many?..... per day
Are you an ex-smoker Yes/No If yes when did you give up? ……..
How long did you smoke ……. How many did you smoke?..... per day
Do you drink alcohol Yes/No In a typical week how many pints?.....
Glasses of wine…….. shorts……
Do you take exercise Yes/No How often?.....

6. FAMILY MEDICAL HISTORY

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Has any close first degree relative of yours suffered from any of the following?

Epilepsy Yes/No High Blood Pressure Yes/No
Glaucoma Yes/No Cancer Yes/No
Diabetes Yes/No Heart Attack or Angina Yes/No
Strokes Yes/No Asthma Yes/No

Please give more details…….

……
…….

7. ARE YOU A CARER?

Do you look after someone who is ill, frail or disabled? Yes/No

8. VACCINATIONS

Have you had polio and tetanus booster? Yes/No
Polio Date……. **Tetanus** Date…….. **BCG** Date……

9. CHILDREN'S IMMUNISATIONS

Please take any immunisation records to surgery when you come for your new patient health check. Please bring your child's health record (red book) to the first meeting with the nurse.

10. WOMEN, TRANS MEN AND NON-BINARY PEOPLE WITH A CERVIX (OR OTHER PEOPLE WITH A CERVIX

Have you had a cervical smear Yes/No When was the last one Date……
What was the result……..

11. NEXT OF KIN Name……. Telephone…….
We would only contact your next of kin in an emergency. We do not divulge confidential information to anyone without your permission.