Aksyr Medical Practice
New Patient Questionniare (under 16years)

Title		**Surname**	
First names		**Preferred name**	

Address			
Postcode		**Email**	
Telephone		**Mobile**	

Date of birth			**First language**	
Were you born in the uk?	Yes ☐ No ☐		**If not when did you move here?**	
Do you need an interpreter	Yes ☐ No ☐		**If Yes, which language**	
What is your ethnicity?			**Are you a carer**	Yes ☐ No ☐
Who is your next of kin?	Name and Relationship		Contact details	

In the case of Child under 16 (who has parental responsibility) Name and Relationship		Contact details	

Have you been registered with a NHS GP before?	Yes ☐ No ☐	**Name and address of previous GP**		
How often do you see your GP?	More than once a month	Monthly	2-3 times a year	Yearly or less
Have you stayed overnight in hospital in the last 3 years?	Yes ☐ No ☐	**If Yes, where and why?**		

Do you have any of these conditions?	**Tick**	**Year**	**Details**
Asthma			
Hayfever			
Chest Disease e.g. emphysema/chronic bronchitis			
Heart Disease			
Stroke			
Diabetes			
Thyroid problems			
Anxiety			
Mental health problems			
Substance abuse problems			
Epilepsy			
Memory problems			
Kidney problems			
Liver problems			
Digestion problems			
Joint problems			
Mobility problems or falls			
Vision problems			
Hearing problems			
Skin problems			
Blood problems			
Anaemia			
Have you had your spleen removed?			
Have you had a transplant?			

Any other serious illnesses or operations	Year	Details

Do you exercise	Yes ☐ No ☐	**What exercise do you do and how often?**			
Are you currently at school?	Yes ☐ No ☐	**What is the name of your school**			
Is your address permanent?	Yes ☐ No ☐	Live with parents	Looked after	Hostel/ homeless	Other

Are there any conditions that run in your family?	Relationship to you	Age affected	Condition

Medication History			
Name of medicine - list all the medicines you use including those you buy from the chemist	**Strength**	**How many you take each day?**	**Where do you get it from?**
Are you currently using contraception?	Yes ☐ No ☐	**If Yes, method and name**	

Are you allergic to any drugs, medicines or food?	**Drug medicine or food**	**What happens**
Which chemist do you use?		

Where did you hear about Canberra Centre for health?		**Why did you decide to register?**	
Are you interested in joining the patient focus group?	Yes ☐ No ☐	**Do you consent to sharing your data within other NHS organisations?**	
Signed		**Date**	