**PEACOCK SURGERY– NEW PATIENT QUESTIONNAIRE**Please complete as much as possible. It can take a long time to receive your medical records. Please return to the receptionist. Thank you.

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| Personal Details | | | | |
| Full Name | | Date of Birth | | |
| Email: | | | | |
| Consent for contact by Text message Yes/No  Consent for contact by email (non-clinical information) | | | | |
| Main spoken language | | | | |
| Do you require interpretation services? | | | | |
| Occupation\*\*\*\*Some patients’ occupation puts them at higher risk medically | | | | |
| Are you a Carer? Yes/No  If Yes, we will send you a carers pack | Do you have a full time Carer? Yes/No  If Yes, we will send you a carers pack | | | |
| Lifestyle questions | | | |
| Weight | | | Height |
| Smoking Status - Please tick  Never smoked  Ex-smoker Date stopped \_\_\_\_\_\_\_\_\_\_\_  Current smoker  Amount smoked daily  \_\_\_\_\_\_\_\_\_\_\_  Would you like advice on stopping? Yes/No | | | Alcohol On average how much alcohol do you drink each week?   ------------------------------------------------ If you think the amount is a problem, please make an appointment with one of the doctors |
| Female Patients | | | |
| When was your last Cervical Smear? | What was the result ?  Normal/ Abnormal/inadequate | | |
| Do you have any allergies to any medication? Please list. E.g. Penicillin | | | |
| Medication: If you take reqular medication or have other items on prescription, please bring in a list from your previous GP. This could be the repeat slip from your prescription. All medication will be reviewed and you may be asked to make an appointment before a prescription is issued. | | | |

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| Medical History. Please tick if you have been diagnosed with any of the following conditions and the approximate diagnosis date. | | | |
|  | Date |  | Date |
| Asthma |  | COPD |  |
| Type 1 Diabetes |  | Stroke or TIA |  |
| Type 2 Diabetes |  | Cancer |  |
| High blood pressure |  | Epilepsy |  |
| Heart disease |  | Depression or mental illness |  |
| Please list any operations, major illnesses or serious medical problems that you have had or are currently being treated for, with approximate dates if known. | | | |
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| Family History - Do any of your immediate family (parents, siblings or grandparents) suffer from or have any major illnesses that you think are relevant? Please tick if applicable and add their relationship to you and approximately how old they were when diagnosed, if known. | | | |
| € Diabetes  € Heart Disease  € Stroke  € Cancer  € Asthma  € Epilepsy  € Other | | | |

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Voluntary information:

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| --- |
| I decline to give this information |
| White | British | Irish | Any other white background |  |
| Mixed | White & Black Caribbean | White & Black African | White & Asian | Any other mixed background |
| Asian or Asian British | Indian | Pakistani | Bangladeshi | Other Asian Background |
| Black or Black British | Caribbean | African | Any other black background |  |
| Other Ethnic Groups | Chinese | Any other ethnic group |  |  |