SPA MEDICAL PRACTICE NEW PATIENT QUESTIONNAIRE

Surname:	**Mr/Mrs/Ms**	**DOB**
Forename(s)	**NHS NO.**	
Address:		
Telephone No.	**Home:**	
Telephone No.	**Mobile:** **We will contact you by text message so tell us if you do NOT want this.**	
Work No.		
Email Address:		

Other members of the household, names and relationship – if under 18 years please add details of parents /Guardian below:

UNDER 18 YEARS PLEASE COMPLETE

Parent/Guardian 1: **Address:** **Contact details**	**Parent/Guardian 2:** **Address:** **Contact details**

Are you homeless?

What is your ethnic group?			
White British or Mixed British	☐	Asian/British Bangladeshi	☐
White Irish	☐	Asian Other	☐
White Other	☐	Black Caribbean	☐
Mixed White/Black Caribbean	☐	Black African	☐
Mixed White/Black African	☐	Black Other	☐
Mixed White/Asian	☐	Chinese	☐
Mixed Other	☐	Other (please specify below)	☐
Asian/British Indian	☐	**Country of birth ?**	
Asian/British Pakistani	☐	**What is your first Language?**	

Are you a carer? **Yes** ☐ **No** ☐ *if yes please complete the yellow card in reception*
Are you cared for? **Yes** ☐ **No** ☐ **Name of carer:**
Relationship of carer:
Tel. No.

Are you Housebound? **Yes** ☐ **No** ☐

Occupation:	**Previously registered with this practice** **Yes** ☐ **No** ☐

Which chemist would you like to nominate as your preferred chemist:-

Boots ☐ **Corbett Pharmacy** ☐
Droitwich Pharmacy ☐ **Other please specify**
St Mary's ☐

Chronic Diseases & Medication

Major Illnesses:	Prescribed Medications(or attach a list)
1.	1.
2.	2.
3.	3.
4.	4.

PLEASE BOOK AN APPOINTMENT IN THE MONTH OF YOUR BIRTH IF YOU HAVE A CHRONIC DISEASE

Do you have an allergy?
Please list here:

Last BP Reading and date	Height	Weight

Do You Smoke Cigarettes
Smoker ☐ If a Smoker how many per day
Never Smoked ☐
Ex-Smoker ☐

IF YOU WOULD LIKE TO STOP SMOKING PLEASE CONTACT YOUR LOCAL PHARMACY FOR SUPPORT

Do you drink alcohol Yes ☐ No ☐	If yes, How many units per week? ☐

Family History of:	
Cancer	Father ☐ Mother ☐ Brother ☐ Sister ☐
Heart Disease	Father ☐ Mother ☐ Brother ☐ Sister ☐
Diabetes	Father ☐ Mother ☐ Brother ☐ Sister ☐
Hypertension	Father ☐ Mother ☐ Brother ☐ Sister ☐
Asthma	Father ☐ Mother ☐ Brother ☐ Sister ☐
Other:	Father ☐ Mother ☐ Brother ☐ Sister ☐
We are a Veteran Friendly Practice	Please tick if you are a veteran ☐