New Patient Questionnaire

Date

Surname …………………………………………………………………………

First name(s)……………………………………………………………………….

Full address **(Permanent/Temporary/No fixed Address)**
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Tel. no Home…………………………………Work……………………………………………..
Mobile Number………………………………………………………………………………….
Email address…………………………………………………………………………………..
Martial status………………………………….Date of Birth…………………………………….
Country of Origin……………………………..Sex……………………………
Ethnicity (White; Black/Black British; Asian/Asian British; Mixed; Chinese; Other please indicate ethnic group)……………………………………………………………………
Occupation……………………………………………………………………………………

First language spoken………………… Do you require the help of an interpreter? (yes/no)

……………………………………………………………………………………………………

GENERAL HISTORY

Please state any requirements you have to be able to access the practice premises.

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Please state any mental or physical disabilities you have.

……………………………………………………………………………………………………

Are you an assistance dog user? (yes/no)…………………………………………………...

Have you had any serious illness or operations, X-rays or similar tests and when?

……………………………………………………………………………………………………

…………………………………………………………………………………………………

What medicines are you taking?
....

……………………………………………………………………………………………………

………………………………………………………………………………………………….

Have you any allergies to medicines or anything else? (yes/no)……………………………

How much tobacco or cigarettes do you smoke on weekly basis?

....

How much alcohol do you consume per week? (Quantity)……………………………………

Wine……………………..Beer……………………..Spirits……………………………………..

CARERS INFORMATION

Do you look after someone? (yes/no)……………………………………………………...

Does someone look after you? (yes/no)…………………………………………………...

FAMILY HISTORY

Which of your blood relations have suffered from the following? (Please tick appropriate boxes)

- Heart Attack ______________________
- Diabetes ______________________
- Asthma ______________________
- Stroke ______________________
- Cancer ______________________
- High Blood Pressure ____________________
- Tuberculosis __________________________

VACCINATIONS – Which vaccinations have you had and when? (Please tick appropriate boxes)

- Diphtheria
- German Measles
- Typhoid
- Cholera
- Yellow fever
- Whooping cough
- Polio
- Tetanus
- Measles
- BCG
- MMR

FOR FEMALE PATIENTS ONLY

Have you had any children? (Yes/No)Give ages__________________________________

Have you had a miscarriage? (Yes/No) Date_____________________________________

Have you had a termination of pregnancy? (Yes/No) Date__________________________
Have you had a hysterectomy? (Yes/No)Date____________________________________

Which method of contraception are you using at present?

____

When was your last smear test? _____________________________________

THE ACCESSIBLE INFORMATION STANDARD (Patients with specific needs only)

In accordance with The Accessible Information Standard (SCCI 1605 Accessible Information) please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual)________________________________

To help me communicate I use (e.g. a talking mat, hearing aids)____________________

I need information in (e.g. braille, easy read)____________________________________

If you need to contact me the best way is (e.g. email, telephone)____________________

HOW DID YOU FIND OUT ABOUT US? Please tick one of the following boxes.

- ☐ Patient banner
- ☐ Friends, Family, Word of mouth
- ☐ Internet
- ☐ Newspaper advert

PROOF OF IDENTITY (**One form of photo ID and one additional document from the list below**) (Office Use):

- ☐ Passport
- ☐ Driving Licence
- ☐ Birth Certificate
- ☐ Tenancy Agreement
- ☐ Utility Bill (3 months)/Bank statement
- ☐ Leave of stay letter (Home Office)
- ☐ NHS Card
- ☐ Other ………………………………………………………..