

RED PRACTICE, WHITEFRIARS SURGERY New Patient Questionnaire

Please complete this form as fully as possible. The information will be of importance to provide you with good medical care until we receive your medical records.

Name

DOB

Occupation

Nationality

Ethnic Group (see attached leaflet)

First Language

Translator required Yes No

Are you a smoker? Yes No

Have you ever smoked? Yes No

How many do you smoke a day

If you have stopped smoking please give the date

Please list any serious illness, accidents, operations, disabilities
Women – please include any problems in pregnancy or at delivery

Please give present state of health and any serious illnesses in the family (if deceased, please state age and cause of death. IN PARTICULAR HISTORY OF HEART DISEASE.

Father

Mother

Brothers

Sisters

Children

What is your height?

What is your weight?

When was your last tetanus and/or polio vaccination?

Please turn over

When and what was your last blood pressure?

You can take your own in the waiting room and provide us with the reading.

Have you any allergies? If so, what?

Do you drink alcohol?

Yes

No

Approximately how much per week?

Are you currently taking any medicines or having any treatment?

Do any medicines upset you?

Yes

No

Are there any concerns about your health you would like to inform your new doctor about?

Have you had a cervical smear test?

Yes

No Year?

Have you had breast screening?

Yes

No Year?

Are you a carer?

Yes

No

Do you have a carer?

Yes

No

Please give the name of address of the person who cares for you or you care for.

Next of Kin (Name & relationship)

Telephone No

Have you an Advance Directive (Living Will)?

Yes

No

If Yes, may we have a copy to file in your medical record?

If No and you would like to know more about this, ask at reception for information