Western Road Medical Practice
New Patient Questionnaire

Surname _____ **Forename** _____

DOB _____ **Marital Status** _____

Address _____

_____

Postcode _____ **Home** _____

Mobile _____ **Email** _____

NHS Number _____

Are you happy to receive info from us by either text or email? YES NO

Height _____ **Weight** _____

Occupation _____ **Next of Kin** _____

Relationship of next of kin _____ **Contact number of next of kin** _____

Is there anyone else registered at this practice you can be linked to?_____

_____**relationship to you** _____

Briefly describe or list any significant past/current medical history

Ie: Asthma, Diabetes, Angina, etc.

_____

_____

_____

Are you currently taking any medication prescribed by the doctor?

Once registered please make a routine appointment with the GP for a medication review.

_____

_____

Carers consent

If you have a carer (or someone else) who you would give consent to access your medical information. Please ask at Reception or download from our website a 'Career Consent Questionnaire'

ARE YOU A CARER?

YES NO Patient Signature: _____

We need to know your alcohol intake
How often do you have a drink containing alcohol? (Please tick the correct answer)

Never		How often do you have 6 drinks or more on one occasion?	Never	
Daily			Monthly	
Weekly			Weekly	
Monthly or Less			Daily	
Ex-Drinker		Date stopped drinking		

What best describes the amount of exercise you do?

Inactive		Gentle	
Moderate		Vigorous	

Which of the following best describes your diet?

Good		Poor	
Vegetarian		Vegan	
Specialist (please specify)			

We need to know your smoking history

Never smoked		Ex-smoker	
Smoker		If so, how many per day?	

Women ONLY

ARE YOU PREGNANT?		Expected delivery date	

If yes, please make an appointment to see a doctor for your ante-natal referral

When was your last Smear test? _____

Please indicate your ethnic origin. This is not compulsory but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Ethnic Origin Please tick one of the following

White British		Greek	
White Irish		Greek Cypriot	
White Scottish		Turkish	
White Welsh		Turkish Cypriot	
Black Caribbean		Italian	
Black African		Polish	
Black British		Kosovan	
Black West Indian		Albanian	
Black Guyana		Bosnian	
Black North African		Croatian	
Black Arab		Serbian	
Black Iranian		Other republic of Yugoslavia	
Black – other African country		Sri Lankan	
Black East African Asian		Israeli	
Black Indo-Caribbean		Kurdish	
Black other Asian		Moroccan	
Black other mixed		Mauritian	
Vietnamese		Romanian	
Indian		Other	
Pakistani			
Bangladeshi			
Chinese		I do not wish to give my ethnicity	

What is your first spoken language?	
If English is not your first language, can you speak English?	

Patient Signature | Date