

Western Road Medical Practice
New Patient Questionnaire – UNDER 16

Surname	Forename
_____	_____
DOB	NHS Number
_____	_____
Address	

Postcode	Home
_____	_____
Mobile	School/College
_____	_____

PARENTAL RESPONSIBILITY - please list all who have parental responsibility (including those living at a different address)

Parent/Guardian	Relationship
_____	_____
Address	

Parent/Guardian	Relationship
_____	_____
Address	

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	<input type="checkbox"/>	How often do you have 6 drinks or more on one occasion?	Never	<input type="checkbox"/>
Daily	<input type="checkbox"/>		Monthly	<input type="checkbox"/>
Weekly	<input type="checkbox"/>		Weekly	<input type="checkbox"/>
Monthly or Less	<input type="checkbox"/>		Daily	<input type="checkbox"/>
Ex-Drinker	<input type="checkbox"/>		Date stopped drinking	<input style="width: 100%;" type="text"/>

What best describes the amount of exercise you do?

Inactive	<input type="checkbox"/>	Gentle	<input type="checkbox"/>
Moderate	<input type="checkbox"/>	Vigorous	<input type="checkbox"/>

Which of the following best describes your diet?

Good	<input type="checkbox"/>	Poor	<input type="checkbox"/>
Vegetarian	<input type="checkbox"/>	Vegan	<input type="checkbox"/>
Specialist (please specify)	<input style="width: 100%;" type="text"/>		

We need to know your smoking history

Never smoked	<input type="checkbox"/>	Ex-smoker	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	If so, how many per day?	<input style="width: 100%;" type="text"/>

Women ONLY

ARE YOU PREGNANT?

<input type="checkbox"/>	Expected delivery date	<input style="width: 100%;" type="text"/>
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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	<input type="checkbox"/>	Greek	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Greek Cypriot	<input type="checkbox"/>
White Scottish	<input type="checkbox"/>	Turkish	<input type="checkbox"/>
White Welsh	<input type="checkbox"/>	Turkish Cypriot	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	Italian	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Polish	<input type="checkbox"/>
Black British	<input type="checkbox"/>	Kosovan	<input type="checkbox"/>
Black West Indian	<input type="checkbox"/>	Albanian	<input type="checkbox"/>
Black Guyana	<input type="checkbox"/>	Bosnian	<input type="checkbox"/>
Black North African	<input type="checkbox"/>	Croatian	<input type="checkbox"/>
Black Arab	<input type="checkbox"/>	Serbian	<input type="checkbox"/>
Black Iranian	<input type="checkbox"/>	Other republic of Yugoslavia	<input type="checkbox"/>
Black – other African country	<input type="checkbox"/>	Sri Lankan	<input type="checkbox"/>
Black East African Asian	<input type="checkbox"/>	Israeli	<input type="checkbox"/>
Black Indo-Caribbean	<input type="checkbox"/>	Kurdish	<input type="checkbox"/>
Black other Asian	<input type="checkbox"/>	Moroccan	<input type="checkbox"/>
Black other mixed	<input type="checkbox"/>	Mauritian	<input type="checkbox"/>
Vietnamese	<input type="checkbox"/>	Romanian	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Other	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>		
Bangladeshi	<input type="checkbox"/>		
Chinese	<input type="checkbox"/>	I do not wish to give my ethnicity	<input type="checkbox"/>

What is your first spoken language?

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

Patient Signature

Date