Western Road Medical Practice

New Patient Questionnaire

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| --- | --- | --- | --- |
| **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 including Allergies** |
| Ie: Asthma, Diabetes, Angina, etc. |
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| **Are you currently taking any medication prescribed by the doctor?** |
| Once registered please make a routine appointment with the GP for a medication review. |
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| **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: |  |

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| **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 |  | Smoker |  |
| Ex-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? |  |  |  |

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| 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 |  |