

**NEW PATIENT INFORMATION**

In order for us to gather as much information as possible before receiving your medical records from your previous doctor, it would be helpful if you could complete this form and hand it to the doctor when you go in for your appointment or to the receptionist before leaving the surgery.

**Please bring two forms of identification when you come to register.**

- 1. one with your photograph on – i.e. passport, driving licence**
- 2. one with your current address on – i.e. paid utility bills, bank statement, payslip**

<b>Title: Mr/Mrs/ Miss/Ms/other</b>	<b>Date of Birth:</b>
<b>First Name:</b>	<b>Surname:</b>
<b>Address:</b>	<b>Occupation/ Job Title:</b>
<b>Post code:</b>	<b>Place of Birth:</b>
<b>Telephone Number:</b>	<b>Mobile Number:</b>
<b>Marital Status:</b>	
<b>Next of Kin: &amp; relationship</b>	<b>Next of kin contact number:</b>
<b>Previous Doctor Name and Address:</b>	<b>Previous Doctors Telephone Number:</b>

**Would you like to have a say about the services provided at your surgery?**

We would love to hear your views! You can do this by coming to an occasional meeting at the practice and talking to practice staff and other patients, or by giving us your email address.

<b>I would like to occasionally be contacted for my views by email</b>  Email address:	
<b>I would like to come to occasional meetings at the practice</b>	

**Patient Ethnic Origin Questionnaire**

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.

Choose ONE section from A to E, and then tick one box to indicate your background.

A White

	British
	Irish
	Any other white background please write in below:

B Mixed

	White and Black Caribbean
	White and Black Asian
	White and Asian
	Any other mixed background please write in below:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write in below:

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background please write in below:

E Chinese or other ethnic group

	Chinese
	Any other please write in below

Do you smoke? Yes  No

Are you a former smoker? Yes  No

Number per day? \_\_\_\_\_ When did you stop smoking? \_\_\_\_\_

**FEMALE PATIENTS ONLY:**

Date of last smear test? \_\_\_\_\_ Where taken? \_\_\_\_\_

**Alcohol :**

How often do you have a drink containing alcohol? (circle one)

Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
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How many units of alcohol do you drink on a typical day when you are drinking? (circle one)

1- 2	3 – 4	5 – 6	7 – 9	10+
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How often have you had 6 or more (if female) or 8 or more (if male) units on a single occasion in the last year? (circle one)

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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How often during the last year have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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How often during the last year have you failed to do what was normally expected from you because of your drinking?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
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Have you or somebody else been injured as a result of your drinking?

No	Yes, but not in the last year	Yes during the last year
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Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

No	Yes, but not in the last year	Yes during the last year
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**Exercise :**

None	Occasional	Regular
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**Diet:** High fat or Low fat

Do you eat your 5 a day? Yes/Usually/No

**Are you a carer for someone?** Yes/No Family member/friend

**Do you have a carer yourself?** Yes/No Family member/friend

**Do you have any of the following diagnosed conditions?**

<b>Coronary Heart Disease</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Diabetes</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Asthma</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Hypertension</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Hypothyroid</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>COPD</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Cancer</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Epilepsy</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Stroke</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>High Blood Pressure</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**ALLERGIES:**

Do you have any allergies? Yes/No

Details: \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

**Is there any family history of the following?:**

<b>High Cholesterol</b>	Details:
<b>Heart Disease</b>	Details:  Diagnosed at: Over 60 <input type="checkbox"/> Under 60 <input type="checkbox"/>
<b>CVA/Stroke</b>	Details:
<b>High Blood Pressure</b>	Details:
<b>Diabetes</b>	Details:
<b>Asthma</b>	Details:

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_