

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. Thank you.

| | | |
|------------------------------------------|--|------------------------------------------|
| Title: Mr/Mrs/ Miss/Ms/other | | Date of Birth: |
| First Name: | | Surname: |
| Address: | | Occupation/ Job Title: |
| Post code: | | Place of Birth: |
| | | Ethnicity: |
| Telephone Number: | | Next of Kin: |
| Mobile Tel. Number: | | Relationship: |
| Marital Status: | | Next of Kin Tel. Number: |
| Previous Doctor Name and Address: | | Previous Doctor Telephone Number: |

HEALTH INFORMATION

Do you smoke? Yes No **Are you a former smoker?** Yes No
Number per day? _____ **When did you stop smoking?** _____

Alcohol : How many units **per day** (approx). _____
 (2 units = 1 glass wine, 1 spirit measure, 0.4 pint of beer)

Exercise : None/occasional/regular/frequent
Type of Exercise: Walking/sport participation/gym/aerobics/other _____

Diet: High fat/low fibre Low fat/high fibre
 Mixture of both above
 (mixture of fruit & veg) Vegetarian/Vegan

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

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

Are you taking any regular medication at the moment? Yes No

If Yes please give details:

FEMALE PATIENTS ONLY:

Date of last smear test? _____ **Where Taken?** _____

Result: Normal Abnormal

If abnormal please supply details:

Do you have any of the following diagnosed conditions?

| | | | | | |
|------------------------|------------------------------|-----------------------------|--------------------------------------------|------------------------------|-----------------------------|
| Coronary Heart Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hypertension | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hypothyroid | Yes <input type="checkbox"/> | No <input type="checkbox"/> | COPD | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Do you suffer from High Blood Pressure? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

FAMILY HISTORY

Is there any family history of the following:

| | | | | | |
|---------------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Cholesterol | Yes <input type="checkbox"/> | No <input type="checkbox"/> | TB | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Father: Alive – Health _____ Dead – cause/age _____

Mother: Alive – Health _____ Dead – cause/age _____

PERSONAL HISTORY

Have you ever suffered from any of the following:

| | | |
|------------------------------------------------------|------------------------------|-----------------------------|
| Fits, faints, blackouts, heat stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Severe headaches, migraine, severe head injury | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Numbness, tingling, muscle weakness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Insomnia, nightmares, sleep-walking or bed-wetting | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Psychiatric illness, depression or nervous breakdown | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If **yes** to any of the above please give details:

Chest pains, angina or heart disease Yes No

Palpitations, shortness of breath, ankle swelling Yes No

High blood pressure, anaemia, leg cramps Yes No

Rheumatic fever, murmurs, diphtheria, scarlet fever Yes No

Bronchitis, pneumonia, pleurisy Yes No

Hay fever or persistent cough Yes No

If **yes** to any of the above please give details:

Dizziness, deafness, ear discharge or noises in the ear Yes No

Frequent catarrh or sore throats Yes No

Inflammation of eyelids, colour or night blindness Yes No

Wearing of glasses or contact lenses Yes No

If **yes** to any of the above please give details:

Chronic indigestion, heartburn, gastric or duodenal ulcer Yes No

Loose motions, 'piles' or bleeding per rectum Yes No

Jaundice or colitis Yes No

Kidney stones, prostatism or urinary infection Yes No

Syphilis or gonorrhoea Yes No

Malaria, dysentery, typhoid or fever etc Yes No

Have you ever worked abroad for long periods? Yes No

If **yes** to any of the above please give details:

- Dermatitis, eczema, psoriasis etc Yes No
- Any allergies Yes No
- Back pains lumbago, sciatica or spinal disorders Yes No
- Arthritis, rheumatism or gout Yes No

If **yes** to any of the above please give details:

- Any operations or hospital admissions Yes No
- Any X Ray examination, blood tests, heart tracings Yes No
- Any special investigations Yes No
- Have you ever had a test for sexually transmitted diseases including AIDS (HIV) or hepatitis Yes No
- Any illness or injury not mentioned above Yes No

If **yes** please give details – date and nature of problem

Have you ever been off work for sickness reasons for longer than two weeks? Yes No
Please give details:

Are you in receipt of any disability pension or industrial injury benefit? Yes No
Please give details:

SIGNED: _____

DATE: _____