NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

Surname: ……………………………………………….. Forename(s): ………………………………

Date of Birth: ………………………………………….. Marital status: ………………………………

Address: ……………………………………………………………………………………………….

…………………………………………………………….… Postcode: …………………………….…..

Home tel: ………………………………………….…… Mobile: ………………………………….….

Email address: ……………………………………………………………………………………….

Occupation: ………………………………………………………………………………………….

Weight (approx): …………………………………….. Height: ………………………………………

Date of completion of this form: ………………………………………………………………….

SMOKING

Do you smoke? Yes / No

If Yes, how many:
Cigarettes per day …….. Cigars per day ……. Ounces of tobacco per day ……..
How old were you when you started smoking? …………………..

EX-SMOKERS

How old were you when you stopped smoking? …………………
How much did you smoke per day? …………………………………..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

For the following questions please circle the answer which best applies
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?

Never   Less than monthly   Monthly   Weekly   Daily or Almost Daily

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 or Almost Daily

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never   Less than monthly   Monthly   Weekly   Daily or Almost Daily

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No   Yes on one occasion   Yes on more than one occasion

DIET

Do you add salt to your food after cooking?   Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit?   Yes / No

Has your Cholesterol been checked in the last 2 years?   Yes / No

EXERCISE

Do you take regular exercise?   Yes / No

If yes, what sort of exercise? ....
How many times per week? ....

FAMILY HISTORY

Is there any of the following in your family (father, mother, brother, sister) before age of 65?

Heart Disease (heart attacks, angina)	Yes / No	Which family member? ....
Stroke?	Yes / No	Which family member? ....
Cancer?	Yes / No	Which family member? ....
	Site of cancer?	

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: …………………………………
Dosage: ………………………………………….

Name of drug: …………………………………
Dosage: ………………………………………….

Name of drug: …………………………………
Dosage: ………………………………………….

ALLERGIES

Are you allergic to any substances, foods or medications Yes / No

If yes, please give details:
……
……

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:
……

Please give details of any treatment for any chronic medical conditions:
……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:
……

IMMUNISATIONS

Dates of Triple/polio/HIB: ………………………………………………………………………………..

Dates of MMR: ……………..…………………………………………………………………………………..

Date of last Tetanus: …………………………………………………………………………………….

FEMALE PATIENTS

Date of most recent cervical smear: …………………………………..
Result of most recent smear: ………………………………………….
Please give details of any complications in pregnancy:
……

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)

Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

GENERAL

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

PHARMACY OPTIONS

Please select a pharmacy for your prescriptions to be sent to:

☐ Morrisons

☐ Lloyds

☐ Verwood Pharmacy

If you choose to use one of the above Pharmacies you will need to liaise with them as there is a form you will need to sign.

If you still wish to collect a paper prescription from the Surgery please tick the box below.

☐ Collect

If you wish to change your choice of Pharmacy please update us on your new choice as soon as possible, to enable us to update your notes.

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.