

NEW PATIENT QUESTIONNAIRE

Thank you for your application to register with Old Oak Surgery. It would be useful to know a little more about your medical history in order to help you. Could you please answer the following questions as accurately as possible? If you have any difficulty in completing this form do not hesitate to ask one of our practice staff to help you.

This information is strictly confidential.

*Delete as appropriate

Marital status:	Single	Married	Divorced	Separated	Cohabiting
Surname:	Forename:				
Date of birth:	Age:	M/F:			
Occupation:	Telephone Number:				
	Mobile Number:				

Refugee / asylum seeker (please circle) Yes / No

Do you require an interpreter Yes / No

Next of kin and contact number:

Have you a carer? Yes / No

If yes name, address and contact number:

PLEASE MARK [YES/NO] IN ANY APPLICABLE QUESTIONS BELOW

Previous Medical History

Please list any operations you have had together with the relevant dates:

Have you ever suffered from the following conditions?

Tuberculosis (TB) Diabetes Asthma Heart Disease Fits / Epilepsy Lung Disease Depression/Anxiety Rheumatic fever

Any other conditions:

Medicines

Please list any prescribed medicines that you may be taking (including tablets, inhalers, injections):

Are you taking any medicines that you buy from a chemist?

Allergies

Are you allergic to any medicines? If yes please list:

Do you or did you used to smoke? Yes / No

If yes how many cigarettes / cigars per day?

If you have stopped smoking, how long ago was this?

Do you drink any alcohol? Yes / No

If yes, on average, how many days a week do you drink

Do you do any exercise?

1-2 times a week [] 2-3 times a week [] More [] Occasional [] Never []

Diet

Do you eat much fibre, eg wholemeal bread, rice, cereals? Yes / No

Do you eat fresh vegetables and fruit? Yes / No

Do you eat any meat or fish? Yes / No

Are you a vegetarian?

Vaccination Details

Have you had a tetanus injection within the last 10 years? Yes / No
(if yes please give approximate date)

Have you had a polio booster in the last 10 years? Yes / No
(if yes please give approximate date)

About Your Family

Please give details of any inherited conditions from your family members, eg, heart disease, heart attacks, strokes, high blood pressure, diabetes, asthma, cancer, high cholesterol. Please specify whom and which illness.

* Father * Mother * Brother * Sister *Grandparents

For Female Patients

Have you ever had a cervical smear test (a test to check for cancer at the neck of the womb)?

If yes where and when was your last test taken? What were the results?

Have you ever been pregnant? Yes / No

Do you have any children? Yes / No

If so how many?

Have you ever had a miscarriage Yes / No or abortion? Yes / No

Are you on any contraceptive? Yes / No

If so which method are you using?

Thank you for taking time to complete this questionnaire; please hand it in to the receptionist. As part of your registration we offer you a brief medical examination with the practice nurse, which will include your weight, height, blood pressure and analysis of your urine.

ETHNIC GROUP RECORDING

In order to meet the needs of the community which we serve and to ensure that everyone has equal access to the healthcare we provide, we need to know which ethnic group you consider yourself belonging to. Please enter the appropriate letter in the box below. Completing the box will help us provide a better service.

If you have any questions or concerns about this please discuss this with a member of the practice staff.

A: White British/Mixed British

B: White Irish

C: White Any Other

D: Mixed White And Black Caribbean

E: Mixed White And Black African

F: Mixed White And Asian

G: Any Other Mixed Background

H: Indian Or British Indian

I: Pakistani Or British Pakistani

J: Bangladeshi Or British Bangladeshi

K: Other Asian Background

L: Caribbean

M: African

N: Other Black Background

O: Chinese

P: Any Other Ethnic Group

Q: Not Stated

I consider myself to belong to Ethnic group []]

Signed.....