




New Patient Questionnaire

IF YOU NEED ANY HELP COMPLETING THIS FORM, PLEASE ASK AT RECEPTION

INFORMATION ABOUT YOU

Family Name		First Name(s)	
Date of Birth		NHS Number	(if known)
Address			
Gender		Marital Status	
Nationality		Country of Origin	
Ethnicity (circle)	White: British, Irish, Other White (specify) Black: Caribbean, African, Other Black (specify) Asian: Indian, Pakistani, Bangladeshi, Other Asian (specify) Mixed: White & Black Caribbean, White & Black African, Other Mixed (specify) Other: Chinese, Not Stated, Other Ethnic Category (specify)		
First Language		Other Languages	
Occupation			
Next of Kin		Contact Number	

YOUR CONTACT DETAILS

 Home		 Work		 Mobile	
e-mail					

MEDICAL INFORMATION

YOUR OWN MEDICAL HISTORY

Please tell us about any chronic illnesses, accidents, operations or disabilities that you have now or have had in the past.

YOUR FAMILY MEDICAL HISTORY

Please tell us about any the medical history of your immediate family (brothers, sisters, parents and grandparents,) especially strokes, heart attacks, cancer etc.

MEDICAL INFORMATION (continued)**MEDICATIONS YOU ARE TAKING NOW**

Please tell us about any medication you are currently taking including the reason and the dosage.

ALLERGIES

Please tell us about any allergies you have

IMMUNISATIONS

Please tell us about any immunisations you have had. If you are registering a child, please provide a copy of their immunisation record if you have it.

ANY HOSPITAL CONSULTANTS YOU ARE SEEING

Name	Speciality	Hospital	☎ Number

ABOUT YOUR LIFESTYLE

Do you smoke?	Yes/No	If yes, how many per day?	
Do you drink alcohol?	Yes/No	If yes, how much in an average week?	
How often do you take exercise?			
What is your height?	Ft/cm	How much do you weigh?	St/Kg
Date of last cervical smear?		Result (if known)	

PREGNANCIES

Please tell us about any pregnancies including the year and outcome

Do you use any form of contraception?	Yes/No	If yes, please give details?	
Have you had a hysterectomy?	Yes/No	If yes, what date?	

**PLEASE MAKE AN APPOINTMENT TO SEE THE PRACTICE NURSE FOR A NEW PATIENT CHECK.
PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU WHEN YOU ATTEND.**

FOR OFFICE USE ONLY

ID Seen:		Checked by:	
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