New Patient Questionnaire Adult

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| **Have you previously been registered with Catshill Village Surgery****YES ⁯ NO ⁯** |

**Administration Details:**

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| **Full Name:** |

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| **Previous or Maiden Name/s:** |

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| **Date of Birth: Sex: M ⁯ F ⁯** |

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| **Address:** |

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| **Contact Telephone: Home: Mobile:** |

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| **Marital Status:** |

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| **Next of Kin Name:****Next of Kin Relationship:****Next of Kin Contact Details:** |

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| **Ethnic Origin:** |

**Care at Home:**

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| **Do you care for anyone who would be unable to manage without your support: YES/NO****Name of Person Cared For:****Address of Person Cared For:****Is this person registered with this practice: YES/NO** |

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| **Are you housebound? YES/NO****Do you have a carer? YES/NO****Carer Contact Details:****Keypad Number:** |

**Thank you for completing this form. By signing the form below you are consenting to your clinical information being shared among other Health Care Professionals with the practice as required.**

**Date: Signature:**

**PLEASE BRING A SPECIMEN OF URINE IN A CLEAN CONTAINER TO YOUR NEW PATIENT CHECK**

**We would be grateful if you would complete this questionnaire before seeing us.**

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| **Any drug allergies: YES/NO****Any other allergies: YES/NO****Current Medicines: (Please include dose if known)** |

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| **Past Medical History:****Details of Any Operations:** |

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| **Family History: Have you or any of your family had any of the following?****Diabetes YES ⁯ NO ⁯****High Blood Pressure YES ⁯ NO ⁯****Heart Attack YES ⁯ NO ⁯****Stroke YES ⁯ NO ⁯****Epilepsy or fit YES ⁯ NO ⁯****Asthma YES ⁯ NO ⁯****Thyroid Disease YES ⁯ NO ⁯****Glaucoma YES ⁯ NO ⁯****Cancer YES ⁯ NO ⁯****Any Congenital Diseases YES ⁯ NO ⁯****Please give details of any condition you have answered “YES” to** |

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| **Do you smoke? YES ⁯ NO ⁯ If “YES” how many per day?****Would you like assistance to stop? YES ⁯ NO ⁯****Have you ever smoked? YES ⁯ NO ⁯**  |

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| **Do you drink? YES ⁯ NO ⁯** **If “YES” how many units per week?** |

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| **THIS SECTION IS FOR WOMEN ONLY****Are you on the contraceptive pill? YES ⁯ NO ⁯****Name of Pill?****How long have you been taking the pill?****Do you have Depo Provera Injections? YES ⁯ NO ⁯** **If “YES” when is your next injection due?****IF YOU ARE USING ANY OF THE ABOVE METHODS OF CONTRACEPTION YOU WILL NEED TO MAKE AN APPOINTMENT FOR A MEDICATION REVIEW WITH THE DOCTOR****Are you fitted with the coil YES ⁯ NO ⁯** **How many children have you had?****When did you last have a cervical smear?****By whom? Doctor/Hospital/Other - please circle** |