New Patient Questionnaire Adult

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

**Administration Details:**

|  |
| --- |
| **Full Name:** |

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

|  |
| --- |
| **Date of Birth: Sex: M ⁯ F ⁯** |

|  |
| --- |
| **Address:** |

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

|  |
| --- |
| **Marital Status:** |

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

|  |
| --- |
| **Ethnic Origin:** |

**Care at Home:**

|  |
| --- |
| **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** |

|  |
| --- |
| **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.**

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

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

|  |
| --- |
| **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** |

|  |
| --- |
| **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 ⁯** |

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

|  |
| --- |
| **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** |