**Catshill Village Surgery**

**New Patient Questionnaire Adult**

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

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

| **Contact Telephone: Home: Mobile:****Contact Email:** |
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| **Marital Status:** |
| --- |

| **Next of Kin Name:****Next of Kin Relationship:****Next of Kin Contact Details:** |
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| **Ethnic Origin:****Main Language Spoken:** |
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**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** |
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| **Are you housebound? YES/NO****Do you have a carer? YES/NO****Carer Contact Details:****Keypad Number:** |
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**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)** |
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| **Past Medical History:****Details of Any Operations:****Do you have any other information we need to be aware of?** **i.e. hard of hearing, visually impaired** |
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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?****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** |
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