**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:** |
| --- |

| **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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