NEW PATIENT QUESTIONNAIRE
(PLEASE WRITE IN BLOCK LETTERS CLEARLY AND IN FULL)

First Name(s): ______________________ Surname ______________________

Preferred Calling Name (if different from above) __________________________

Date of Birth Day _______ Month ___________ Year _____________

Address (including post code) ____

____ Post code __________

Home Tel Number _________________

The practice uses an SMS text messaging service to mobile phones to remind patients of their appointments etc. Are you happy to participate in this service? **Yes / No**

Mobile Number ______________________

What is your first language? ________________________ eg: English/Polish etc

What is your ethnicity? ______________________ eg: British or mixed British / Chinese

What is your occupation? ___________________________

GENERAL INFORMATION

Medication

Do you take any regular medication prescribed by your previous GP? **Yes / No**
(**If yes** the practice will need to see your repeat list issued by your previous GP. If this is not available it will be necessary for us to contact your previous GP for confirmation before any medication can be issued by this practice).

Smoking Habit

Are you a current smoker? **Yes / No**

If yes – what do you smoke? ___________________ How many per day? _______

If no - have you ever smoked? **Yes / No** **what year did you stop? ________**

Please answer the next question as fully as possible. If you answer yes this will not have an adverse effect on your treatment at the surgery but will help to ensure that you obtain the correct diagnosis and treatment plan.

Do you use recreational drugs? **Yes / No** **If yes – what drug? _________**

Exercise

Do you take regular exercise? **Yes / No** **If yes – How often? ________________**

(PTO)

Alcohol

How many units of alcohol do you drink a week? ___________________________

(One unit = around ½ pint of lager/beer or one small glass of wine or one single measure of spirit)

(For the following questions please circle the answer that applies to you)

How often do you have a drink that contains alcohol?

Never / monthly or less / 2-4 times per month / 2-3 times per week / 4+ times per week

How many standard alcoholic drinks to you have on a typical day when you are drinking? **1-2 / 3-4 / 5-6 / 7-8 / 10+**

How often do you have 6 or more standard drinks on one occasion?

Never / Less than monthly / Monthly / Weekly / Daily or almost daily

Carer

Are you a carer **Yes / No**

If yes – is the patient for whom you care registered at this practice? **Yes / No**

Allergy

Do you have any allergies? **Yes / No**

If yes – What are you allergic to? ____

For Female Patients Only – When was your last smear? _________________

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FOR GP / NURSE TO COMPLETE AT NEW PATIENT CHECK

Ht	**Wt**	**BP** **PULSE**
FH		
PMH		