

New Patient Questionnaire



Catherine House
SURGERY

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DATE:

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Please answer as many questions as you can by either writing in the spaces provided or circling when required. As it often takes some time for the surgery to receive your previous health records the information you give is important in enabling us to deliver good medical care.

YOUR DETAILS

Title: Mr / Mrs / Miss / Ms / Dr / Other _____

Gender: Male / Female / Preferred term

Surname: _____

(please state) _____

First name(s): _____

Date of birth: _____

Full address: _____

Ethnicity: _____

Occupation: _____

_____ Postcode _____

Tel no. HOME _____

Height: _____

MOBILE _____

Weight: _____

Email: _____

Main language spoken: _____

Second language: _____

Next of kin and their contact no: _____

I give my consent for the surgery to contact me by text and/or email.

SIGNED:

DATE:

Are you a carer? *YES / NO* If yes, please give brief details: _____

Are you being cared for? *YES / NO* If yes, what is your carer's name? _____

Have you ever served in the British Armed Forces (regular or reserves)? *YES / NO*

Do you have any specific communication needs? *YES / NO*

If yes, please give details: _____

MEDICAL AND DRUG HISTORY

Please provide details of any **significant current/past medical history e.g. serious illnesses, operations:**

PLEASE TURN OVER

Have you ever suffered from:

Epilepsy	YES / NO	Diabetes	YES / NO	High blood pressure	YES / NO
Heart Attack	YES / NO	Cancer	YES / NO	Asthma / COPD	YES / NO
Stroke	YES / NO	Depression	YES / NO		

Have you ever had the 'flu' vaccination? YES / NO If yes, when? _____

Have you ever had the pneumococcal vaccination? YES / NO If yes, when? _____

What medicines are you currently taking? (Please attach list if easier) _____

Do you have any allergies to medicines and/or other substances (e.g. foods)? If yes, please state the allergy and the reaction you experienced, e.g. rash, swelling.

SMOKING AND ALCOHOL HISTORY

Are you a smoker? YES / NO If yes, how many cigarettes daily? _____

Have you ever smoked? YES / NO If yes, when did you stop? _____

How many units of alcohol do you drink each week?
_____ UNITS

2 units =
1 pint of normal beer (3.6%)



2 units =
175ml standard glass of wine (12%)



1 unit =
25ml single spirit shot (40%)



1.5 units =
275ml alcopops bottle (5%)



How often in the last year have you had at least 6 units (if female) or 8 units (if male) on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily / almost daily
How often in the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily / almost daily
How often in the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily / almost daily
Has anyone been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

FAMILY HISTORY

Have any direct family members (parents, brothers or sisters) had any of the following:

Heart Attacks	YES / NO	Cancer	YES / NO	Stroke	YES / NO
Diabetes	YES / NO	Blood clots	YES / NO	High blood pressure	YES / NO

FOR FEMALE PATIENTS ONLY

Have you had any children? YES / NO If yes, please give ages: _____

Have you have a hysterectomy? YES / NO If yes, please give year: _____

When was your last smear test? _____ Are you fitted with a coil? YES / NO