NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

(NB all information supplied will be recorded in your confidential medical records)

**Surname:** ………………………………………**Forename(s):** ……………………………………

**NHS number:**...........................................................................................................................

**Date of Birth:** ………………………… **Marital status:** ….………………………………………..

**Address:** ………………………………………………………………………………………………

……………………………………………………………….…………**Postcode:** ....…………..….

**Home tel:** ……………………………… **Mobile (if aged 16 and over):** ………………………….

**Previous GP:** …………………………………………………………………………………………

**Previous GP telephone address:** …………………………………………………………………..

**Gender:** ……………………………………………………………………………………………….

**Are you under 18 years old?** Yes  No

**Language preference:** English  Welsh  Other (please specify below)

Other: ………………………………………………………

**Do you consent to the practice contacting you by text message** Yes  No

**Email address:** …………………………………………………………………………………………

**Do you consent to the practice contacting you by email** Yes  No

**Next of kin details:**

**Surname:** ………………………………………**Forename(s):** ……………………………………

**Home tel:** ……………………………… **Mobile:** ………………………………

**Relationship to you (e.g. partner, mother, brother etc):**……………………………………

**Are any members of your household registered at the Practice?**

|  |  |  |
| --- | --- | --- |
| **Name** | **DOB** | **Relationship to you** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**What is your ethnic origin?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Asian or Asian British** | | | |
| Indian |  | Pakistani |  |
| Bangladeshi |  | Chinese |  |
| Any other Asian background |  |  | |
| **Black, Black British, Caribbean or African** | | | |
| Caribbean |  | African |  |
| Any other Black, Black British, or Caribbean background |  |  | |
| **Mixed or multiple ethnic groups** | | |  |
| White and Black Caribbean |  | White and Black African |  |
| White and Asian |  |  |  |
| Any other Mixed or multiple ethnic background |  |  | |
| **White** | | | |
| English, Welsh, Scottish, Northern Irish or British |  | Irish |  |
| Gypsy or Irish Traveller |  | Roma |  |
| Any other White background |  |  | |
| **Other ethnic group** | | |  |
| Arab |  |  |  |
| Any other ethnic group |  |  |  |

**SMOKING**

**Do you smoke?** Yes  No

**If *Yes*, how many:** Cigarettes per day …….. Ounces of tobacco per day ……..

**ALCOHOL**

For the following questions please answer to the best of your knowledge: We have provided a basic guide to alcohol content below to assist your completion:

*A 750ml bottle of wine contains 10 units*

*A standard (175ml) glass of wine contains 2 units*

*A single small shot of spirits (25ml) contains 1 unit*

*A standard 70cl bottle of spirits contains 28 units*

*A pint of 3.6% strength lager/beer/cider contains 2 units*

*A pint of 5.2% strength lager/beer/cider contains 3 units*

**How many units of alcohol do you drink a week?** ………………………………

**HEIGHT AND WEIGHT**

**Please tell us your most recent measurements for the following:**

**Height: ………………………..**

**Weight: ……………………….**

*Please note, we may contact you to offer you support or advice if appropriate based on your submission.*

**FAMILY HISTORY**

**Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?**

Heart Disease? Yes  No  which family member? ………………………….

Stroke? Yes  No  which family member? ………………………….

Cancer? Yes  No  which family member? ………………………….

Site of cancer? …………………………………………………………………………………….

**MEDICATION**

**Please give details of any medication which you take (prescribed or otherwise):**

|  |  |
| --- | --- |
| **Name of drug** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**\*\*\*Please attach or forward us your most recent repeat medication slip\*\*\***

**ALLERIGES**

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

**If *Yes*, please give details:**

……………………………………………………………………………………………………………

**PAST MEDICAL HISTORY**

**Please give details of any treatments/medical conditions you have:**

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**FEMALES ONLY – When was the date of your last smear test** ………………………………

**CARERS**

**Do you need/have anyone who looks after you or your daily needs as Carer?**

Yes  No

**If *Yes*, would you like them to deal with your health affairs here?** Yes  No

*(A member of reception staff can help with these arrangements)*

**Do you care for anyone else?** Yes  No

*(If Yes, please ask the reception staff about Carers support)*

**MILITARY VETERAN**

**Have you ever served in the Armed Forces?** Yes  No

**COMMUNICATION**

Do you have any communication/information needs relating to sensory loss and, if so, what are they and how would you like us to communicate with you?

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

***Thank you for completing this questionnaire.***