Please select a **preferred pharmacy:** _____ (If you leave this blank, we will select Stockbridge Pharmacy)

NEW PATIENT QUESTIONNAIRE

Welcome to the Green Practice. Please complete the following details to help us provide for your needs. This is in **strict confidence** and will not be passed to anyone without your consent. Thank you for completing this questionnaire.

Surname: _____ Forenames(s): _____

Date of birth: ___/___/____ Occupation: _____

Address: _____ Postcode: EH_____

Tele: _____ Mobile: _____

Email: _____

Do you consent to receive text messages from the practice? **Y/N**

MEDICAL CONDITIONS

Please make a GP appointment to obtain regular medication

1. _____ Diagnosed : ___/___/____
2. _____ Diagnosed: ___/___/____
3. _____ Diagnosed: ___/___/____
4. _____ Diagnosed: ___/___/____
5. _____ Diagnosed: ___/___/____

REGULAR MEDICATION

1. _____
2. _____
3. _____
4. _____
5. _____

Diseases that can run in the family

(Has anyone in your family ever had?)

Heart Disease _____ Age _____
High blood pressure _____ Age _____
Stroke _____ Age _____
Diabetes _____
Asthma _____
Eye disease _____
Cancer _____
Thyroid disease _____
Epilepsy/fits _____
Other _____

WOMEN ONLY

Have you ever had a cervical (pap) smear test? **YES/NO**
When? ___/___/_____ (provide year at least)
Taken by: **GP/FPC/Hospital/Overseas** - _____
Result: **Normal/Early Recall/Colposcopy**
Current method of contraception:
Pill/Implant/Coil/None/Other _____

When was your implant/coil fitted? ___/___/_____

What type of coil do you have fitted? (please circle)
Mirena Copper Jaydess Kyleena Levosert Other _____

For what purpose are you using the coil?
HRT/contraception/heavy periods/other _____

Marital status: single/married/divorced/widowed/separated/partner

Next of kin: _____ Tele: _____

Who lives with you? _____

ETHNIC GROUP: *(please advise)* _____

Interpreter required? **YES/NO**
If yes, what language: _____

CONSENT for other health professionals to view your relevant medical information (i.e. paramedics/A&E)
YES/NO Signed: ..... Date: .....

ALLERGIES

Are you allergic to any medicines? **YES/NO**

Name of drug(s): _____

If yes, severity: mild/moderate/severe
certainty: possible/likely/certain
reaction: (e.g. rash/swelling) _____

Any other allergies? _____

SMOKING

Have you ever smoked? **YES/NO**
Do you currently smoke? If yes, how much? _____
If an ex-smoker, when did you stop? _____

Do you use solvents or drugs? **Regularly/Sometimes/Never**

ALCOHOL

What is your alcohol intake?

Daily _____ units Weekly _____ units
(1 unit = measure of spirit or small glass of wine)

CHILDREN (UNDER 5 YEARS OLD ONLY)

Immunisations to date—Please provide their Red Book or equivalent immunisation records.

Parent(s) of children aged 0-16 years:

1. Has your child ever been on an "At Risk"/Child Protection Register at any time? **YES/NO**
2. Does your child/family have any social work involvement? **YES/NO**
3. Does your child have a learning disability? **YES/NO**

DO YOU look after a relative, partner or friend who needs support because of age, physical or learning disability or illness, including mental health? **YES/NO**

Support available: http://www.vocal.org.uk/

Is there anything else you feel we need to know about your health? (e.g. currently pregnant)

_____
_____
_____
_____
_____