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: _____Work no: _____

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: .....

## 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. _____

## 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)*

## 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 _____

## 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/

## 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 is your implant/coil due for removal? ___/___/_____

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

_____
_____
_____
_____
_____

Have you had your COVID-19 vaccine? Please provide dates below:
**Kind**: _____ **1st dose:** ___/___/_____
(e.g. AstraZeneca, Pfizer, etc.) **2nd dose:** ___/___/_____