Confirmation of address: Lease/Mortgage/Council Tax/Utility Bill. ID: Driving License Passport/Valid Visa where appropriate

NEW PATIENT QUESTIONNAIRE

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

Surname _____ Forename(s) _____

Date of Birth ___/___/___ Age ___ Occupation _____

Address _____ Post Code: EH _____

Tele: _____ Mobile: _____

e-mail: _____ Work Number: _____

MEDICAL CONDITIONS
Please arrange appointment with GP to obtain regular medication

1_____ Date __/__/__

2 _____ Date __/__/__

3 _____ Date __/__/__

4 _____ Date __/__/__

5 _____ Date __/__/__

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 _____

Is there anything else you feel we should know about your YES/NO health? (e.g. currently pregnant)
_____
_____
_____

Marital Status: Married/Single/Widowed/Divorced/Separated/Partner

Next of Kin: _____ Tele: _____

Who Lives with you: _____

ETHNIC GROUP: _____
Interpreter needed? Yes/No

CONSENT for other health professional to view relevant medical information on contacting Out-of-Hours/A&E/SAS 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: rash/swelling etc
Any other allergies? _____

SMOKING
Have you ever smoked? YES/NO
Do you currently smoke: If yes, how much: _____

If an ex-smoker, when stopped? _____
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 half-pint or small glass of wine

Parent(s) of Children aged 0-16 years:
Has your child ever been on an "at Risk"/ Child Protection Register at any time? yes/no
Does your child/family have any social work involvement? yes/no
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 ill health? YES/NO
Support: http://www.vocal.org.uk/

CHILDREN ONLY
Immunisations to date – Please provide evidence e.g. Red Book or equivalent

WOMEN ONLY
Have your ever had a cervical (pap) smear test?
When? ___/___/___ (year at least)
Taken by: GP/FPC/Hospital/Overseas
Result: Normal/Early Recall/ Colposcopy

Thank you for completing this questionnaire. Please sign and date below, and arrange suitable appointments for repeat medication/new patient check.

Signature …….. Date …….