

**NEW PATIENT QUESTIONNAIRE**

Please complete the following information and attached forms. It is important that we have all your current details in order to process your registration.

You can be assured that all information is confidential.

Today's date: ..... DOB: .....

Your full name: .....

Current address: .....

.....

Postcode: .....

Home tel. no: ..... Work tel. no: .....

Mobile no: ..... Email : .....

Is this a permanent address: YES / NO

Are you intending to live at this address for the next 12 months: YES / NO

Previous address: .....

.....

Date of address change: .....

Name & address of current doctor: .....

.....

Reason for change: .....

Please list current medications:

.....

.....

**Member of staff to confirm identification seen (please tick relevant box):-**

Birth Certificate	<input type="checkbox"/>	Driving Licence	<input type="checkbox"/>	Passport	<input type="checkbox"/>
Allowance Book	<input type="checkbox"/>	Rent Book	<input type="checkbox"/>	Utility Bill	<input type="checkbox"/>
Other (please specify):-					
Identification Seen By:- (Member of staffs name)					
Date identification seen					

Next of kin details: .....

Tel: .....

Do you care for someone?

YES – NO

Does someone care for you?

YES - NO

If yes, please complete the form attached at the back of this questionnaire

**Ethnic Origin:**

- |                                      |                                   |   |
|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> British     | <input type="checkbox"/> Irish    | <input type="checkbox"/> other white background |
| <input type="checkbox"/> Carribean   | <input type="checkbox"/> Africian | <input type="checkbox"/> other black background |
| <input type="checkbox"/> Indian      | <input type="checkbox"/> Pakistan | <input type="checkbox"/> Bangladeshi            |
| <input type="checkbox"/> other asian | <input type="checkbox"/> Chinese  | <input type="checkbox"/> other ethnic group     |

**Main language spoken:** .....

**Medical History**

Please list all serious illnesses, operations or disabilities, together with the date of onset:

.....

.....

.....

Have you suffered from:

- |                          |          |       |
|--------------------------|----------|-------|
| Heart attack             | YES – NO | ..... |
| Stroke                   | YES – NO | ..... |
| High blood pressure      | YES – NO | ..... |
| Diabetes                 | YES – NO | ..... |
| Asthma                   | YES – NO | ..... |
| Chronic Airways Disease  | YES – NO | ..... |
| Epilepsy                 | YES – NO | ..... |
| Hypothyroidism           | YES – NO | ..... |
| Mental Health/Depression | YES – NO | ..... |

**Medication**

Do you take any regular medication? YES – NO

If 'yes', do you require your medication within the next month? YES – NO

**Allergies**

Are you allergic to any medicines YES – NO

If 'yes' please list them: .....

**Family history**

Is there any family history of the following (if 'yes' please give details i.e. relationship and type of problem)

- Heart disease YES / NO .....
- Asthma YES / NO .....
- Diabetes YES / NO .....
- Stroke YES / NO .....
- Cancer YES / NO .....
- Stomach probs YES / NO .....

**Smoking status**

- 1. DO YOU CURRENTLY SMOKE? YES / NO  
(if 'yes' please go to question 4)
- 2. IF 'NO' HAVE YOU EVER SMOKED? YES / NO
- 3. IF 'YES' PLEASE GIVE QUIT DATE .....
- 4. IF YOU DO SMOKE, WOULD YOU LIKE TO QUIT? YES / NO
- 5. HOW MANY CIGARETTES DO YOU SMOKE A DAY? .....

**THE SMOKING CESSATION SERVICE OFFERS HELP & SUPPORT TO SMOKERS WISHING TO QUIT. THEY CAN BE CONTACTED ON : 01254 380424**

Many smokers underestimate the risks of smoking. Smoking is dangerous. Cigarettes contain the following:*Nicotine* –a drug that stimulates the brain. When the blood level of nicotine falls, the smoker develops symptoms such as anxiety, headaches and irritability. These are relieved by the next cigarette. Nicotine is a drug of addiction and dependency.

*Tar* – deposits on the lungs causing lung disease.

*Carbon monoxide* – gets into the bloodstream and damages blood cells and arteries in all parts of your body.

Here are some of the many diseases caused by smoking; *lung cancer, chronic bronchitis, emphysema, heart disease, ear, nose & throat cancers, leukaemia, cervical cancer, hardening of the arteries, stroke, osteoporosis, Raynaud's phenomenon and many more.*

Smoking is also expensive. Potential friendships or romances may be jeopardised as people are now recognising the risks of passive smoking. Your insurance company will charge you more on your life insurance if you are a smoker.

**Women**

Have you had a cervical smear in the last 3 years? YES – NO

**PLEASE HAND THIS QUESTIONNAIRE INTO RECEPTION. YOU MAY BE ASKED TO MAKE AN APPOINTMENT WITH THE DOCTOR OR NURSE.**