New Patient Questionnaire

Today's Date: ______

Surname ______ **Previous Surname(s)** ______

Forenames ______ **Marital Status** ______

Date of Birth ______ **Occupation** ______ **Work tel. no.** ______

Telephone no. Home: ______ **Mobile no.** ______

Next of kin (name and contact phone no.) ______

Other family members at the same address ______

What is your ethnic group? Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group

A. White	**B. Mixed**	**C. Asian or Asian British**	**D. Black or Black British**	**E. Chinese or other ethnic group**
☐ British	☐ White + Black Caribbean	☐ Indian	☐ Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Pakistani	☐ African	☐ Any other
☐ Other (write in)	☐ White and Asian	☐ Bangladeshi	☐ Any Other Black background	....
....	☐ Any Other Mixed	☐ Any Other Asian	(write in)	

Carers: Do you look after someone or does someone regularly help you? (please give details)

______

Height: ______ **Weight:** ______

Do you smoke? (please tick)
☐ Yes - ______ daily (please indicate number)
☐ No - given up when?______ how much did you used to smoke? ______
☐ No - Never smoked

How much alcohol do you drink per week? ______ units
(1 unit = 1 small glass of wine / 1 single spirit / half pint beer)

Please list any allergies to medication ______

How often do you exercise? ______ per week. What type of exercise? ______

What type of diet do you have?-please circle:-

mixed diet / unhealthy / vegetarian / low fat / diabetic / other- please specify ______

Operations, Major illnesses and Medical Conditions + date / year (continue overleaf if necessary)

______

______

______

Repeat Medication Please list name, dose, and no. of times it is taken daily:

______

______

______

Tetanus- date of last booster ______

Family History Do you have parents, brothers or sisters who have had any of the following?

Diabetes ______ Heart Attack ______
Bowel cancer ______ Heart Attack under the age of 60 ______
Breast cancer ______ Thyroid disorder ______
Stroke ______ Any other important family illness ______

Women Only: **Method of contraception** if used ______

Date of last smear ______ result? ______

Date of mammogram if applicable ______

Please list any pregnancies ______

______

Thank you for completing this form