New Patient Questionnaire

DATE:	Version 2.0 18/07/2016

Please answer as many questions as you can by either writing in the spaces provided or circling when required. As it often takes some time for the surgery to receive your previous health records the information you give is important in enabling us to deliver good medical care.

Catherine House SURGERY

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YOUR DETAILS

Title: Mr / Mrs / Miss / Ms / Dr / Other _____ Male / Female

Surname: _____ Date of birth: _____

First name(s): _____ Marital status: _____

Full address: _____ Ethnicity: _____

_____ Occupation:

_____ Postcode _____ _____

Tel no. HOME _____ Height: _____

MOBILE _____ Weight: _____

Email: _____

Main language spoken: _____ Second language: _____

Next of kin and their contact no: _____

I give my consent for the surgery to contact my next of kin in the case of an emergency.

SIGNED: DATE:

Are you are carer? *YES / NO* If yes, please give brief details: _____

_____

Are you being cared for? *YES / NO* If yes, what is your carer's name? _____

Have you ever served in the British Armed Forces (regular or reserves)? *YES / NO*

Do you have any specific communication needs? *YES / NO*

If yes, please give details: _____

MEDICAL AND DRUG HISTORY

Please provide details of any **significant current/past medical history e.g. serious illnesses, operations**:

_____

_____

_____

_____ **PLEASE TURN OVER**

Have you ever suffered from:

Epilepsy	*YES / NO*	Diabetes	*YES / NO*	High blood pressure	*YES / NO*
Heart Attack	*YES / NO*	Cancer	*YES / NO*	Asthma / COPD	*YES / NO*
Stroke	*YES / NO*	Depression	*YES / NO*		

Have you ever had the 'flu' vaccination? *YES / NO* If yes, when? _____

Have you ever had the pneumococcal vaccination? *YES / NO* If yes, when? _____

What medicines are you currently taking? (Please attach list if easier) _____

_____

_____

_____

Do you have any allergies to medicines and/or other substances (e.g. foods)? If yes, please state the allergy and the reaction you experienced, e.g. rash, swelling.

_____

SMOKING AND ALCOHOL HISTORY

Are you a smoker? *YES / NO* If yes, how many cigarettes daily? _____

Have you ever smoked? *YES / NO* If yes, when did you stop? _____

How many units of alcohol do you drink each week?

_____ UNITS

2 units = 1 pint of normal beer (3.6%)

2 units = 175ml standard glass of wine (12%)

1 unit = 25ml single spirit shot (40%)

1.5 units = 275ml alcopops bottle (5%)

How often in the last year have you had at least 6 units (if female) or 8 units (if male) on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily / almost daily
How often in the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily
How often in the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily
Has anyone been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

FAMILY HISTORY

Have any direct family members (parents, brothers or sisters) had any of the following:

Heart Attacks	*YES / NO*	Cancer	*YES / NO*	Stroke	*YES / NO*
Diabetes	*YES / NO*	Blood clots	*YES / NO*	High blood pressure	*YES / NO*

FOR FEMALE PATIENTS ONLY

Have you had any children? *YES / NO* If yes, please gives ages: _____

Have you have a hysterectomy? *YES / NO* If yes, please give year: _____

When was your last smear test? _____ Are you fitted with a coil? *YES / NO*