BOURTREEHILL MEDICAL PRACTICE

Registering Staff Member…….

# NEW PATIENT QUESTIONNAIRE 15 YRS or over

**Please answer all questions as fully as possible with a small tick in the appropriate box, provide additional details where requested, and return your form to the GP Practice Reception desk. If there is not enough room on the form for your needs, please add comments on a separate sheet.**

**Please note that it is practice policy that no one can be registered, and therefore no-one can receive proper services from this practice, until they have read, completed and handed in this questionnaire.**

**SURNAME……FORENAME(s)……**

**DATE OF BIRTH……..…SEX Male/Female…….**

**ADDRESS……**

**POSTCODE…….....……..…... TODAY'S DATE……**

**TELEPHONE Home……..... Mobile ……**

**ETHNICITY (Please choose from list below)……**

**1. White Scottish. 2. White Irish. 3. Other White British Ethnic Group. 4. Other White Ethnic Group.**
**5. Indian. 6. Pakistani. 7. Bangladeshi. 8. Other Asian Ethnic Group. 9. Chinese. 10. Black Caribbean.**
**11. Black African. 12. Other Black. 13. Other Ethnic, Mixed Origin. 14. Other Ethnic Group.**

**HAVE YOU BEEN REGISTERED WITH US BEFORE? ☐ YES ☐ NO**

1. **DRUG ALLERGIES.** Please list any drug allergies of which you are aware:

2. **OTHER ALLERGIES.** Please list any other allergies of which you are aware:

3. **PLEASE TELL US YOUR HEIGHT** **Ft/inches……..……**or **in Metres……..…..**

4. **PLEASE TELL US YOUR CURRENT WEIGHT**

**stones/pounds……..**or **in kilos:…….**

5. **FAMILY HISTORY –THINKING OF YOUR PARENTS/BROTHERS/SISTERS**

**(Delete as appropriate or leave if not sure)**
**Are/were any Diabetic? YES/NO**
**Any had heart attacks or Angina developed: a) Before Age 60 YES/NO b) After Age 60 YES/NO**

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**6. CURRENT MEDICATION –** Please attach the right hand side of a current prescription showing your present medication, or write below any current or repeat prescribed medicines that you are taking). Please contact us a week after handing in your form to make a routine double appointment with a GP if you are on repeat medication (medicine you take all the time).

| **Name of drug** | **What for?** | **Dose in mgs** | **How many Tabs/When?/How often?** |
|---|---|---|---|
| (ie Ibuprofen | Arthritis | 400mgs | 1 tab three times a day ) |

1……..
2……..
3……..
4……..
5……..
6……..
7……..

**7. SMOKING**

**CURRENT SMOKER** ☐ **YES** **If yes, how many per day?……**
**EX-SMOKER** ☐ **YES** **When did you stop?.....…….**
**NEVER SMOKED** ☐ **YES**

**8. ALCOHOL CONSUMPTION**
**(Approximately, 1 pint of beer is 2 units, a large glass of wine is 2 units, a double 'short' is 2 units)**

**NUMBER OF UNITS CONSUMED PER WEEK……or None** ☐

**9. (FEMALE PATIENTS ONLY)**

**DO YOU CURRENTLY HAVE A COIL FITTED?** ☐ **YES** ☐ **NO**

**DO YOU CURRENTLY HAVE A CONTRACEPTIVE IMPLANT?** ☐ **YES** ☐ **NO**

**10. (ALL PATIENTS) PLEASE ADD BELOW ANY OTHER COMMENT OR INFORMATION YOU FEEL IS RELEVANT**

**REGARDING ANY OF YOUR RECORDS, RELEVANT DATA WILL BE SHARED WITH APPROPRIATE AGENCIES AND MUST MATCH THE DECLARATION THAT YOU SIGN.**

(OFFICE USE – INITIAL PLEASE) – TO BE SEEN BY GP ☐ or: NFA ☐ DATA ENTRY ☐ SCANNED & TO ARCHIVE ☐