

**THE LONG HOUSE SURGERY
NEW PATIENT QUESTIONNAIRE**

Date _____

Title Mr/Mrs/Ms/Miss/Dr (please circle) Other _____(please state)

Status: married/single/divorced/separated (please circle)

Surname _____ Forename(s) _____

Any former surnames _____

Date of birth _____ Occupation _____

Address _____

Postcode _____

Tel Nos. Home _____ Work _____ Mobile _____

Have you previously been registered with this Practice? - Yes/No (please circle)

Previous address (as registered with your last GP) _____

Name and address of last GP _____

Next of Kin/Contact _____

Address _____

Post Code _____

Tel No. _____

P.T.O

Nov 09

Carer

A carer is someone of any age, who provides unpaid help and support to a partner, child, relative friend or neighbour who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability, Please note this does not include normal parental care.

In order to determine your needs and provide you with the relevant support and resources to maintain your health, we need to know whether you are a carer for somebody or you yourself have a carer. The above is a definition of a carer and after you have read this, please answer the questions that follow.

a) are you a carer? *Yes/No (if yes please provide the following details of the person you care for)

Name:

Address:

b) Do you have a carer *Yes/No (if yes please provide the following details of your carer)

Carers name:

Carers address:

Signature of patient

FOR OFFICE USE ONLY

Birth Cert

Photo ID Type

Other

Proof of address Type

May 10

We would be grateful for some medical information about you as it can take a few months to get your health record from your previous Doctor.

Please circle, tick or fill in the appropriate boxes below

Do you smoke? Yes/No
If No have you ever smoked Yes/No When/which year did you stop? _____
If Yes how many do you smoke a day? _____
Do you wish smoking cessation support Yes/No/Not applicable

Alcohol: Units per week _____
(one unit = ½ pint or 1 glass of wine or 1 single spirit measure)

Allergies: Yes/No If yes to what _____

Current Regular Medication

Drug Name	Dose (e.g. 10mgs)	Frequency (e.g. 2 at night)

FEMALES ONLY

Cervical smear: Date of last smear _____
Result: Normal/abnormal*
Where taken: _____
e.g. Family Planning, Edinburgh or Name and address of GP
Next smear advised in _____* months/year
I have never had a cervical smear please tick box
*(delete as appropriate)

Personal medical history

Have you ever been diagnosed with?

	Year Diagnosed		Year Diagnosed
Asthma	_____	Diabetes	_____
Emphysema/chronic bronchitis Chronic obstructive airways disease	_____	Epilepsy	_____
Heart attack/coronary/MI	_____	Thyroid problems	_____
Angina	_____	Stroke	_____
Hypertension/high blood pressure	_____	Heart failure	_____
Cancer Please specify type (e.g. lung)	_____		

_____ **Any other relevant significant medical history please add on a separate sheet**

Family History

	Relation affected	Approx. age onset
Myocardial Infarction (MI)	_____	_____
Angina	_____	_____
High Blood pressure	_____	_____
Stroke/mini stroke	_____	_____
Diabetes – insulin/non-insulin	_____	_____

Any other significant family history

The following section is **optional** for completion, but we hope you are willing to do so as this will enable the needs of patients from different groups and the NHS and social services required to be identified.

Name: _____ **DOB** _____

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

A: White

- British
- Irish
- Any other White background, please state

B: Mixed

- White and Black Caribbean
 - White and Black African
 - White and Asian
 - Any other mixed background, please state

C: Asian or Asian British

- Indian
- Pakistani
- Bangladeshi

- Any other Asian background, please state

D: Black or Black British

- Caribbean
- African
- Any other Black background, please state

E: Other Ethnic Group

- Please state

F: Refused to Complete