STOVELL HOUSE SURGERY

NEW PATIENT QUESTIONNAIRE (Over age 14)

Please complete in CAPITAL LETTERS **These details are essential***

* Title Mr/Mrs/Miss/Ms/Other…… * Sex Male ☐ Female ☐

* First Name(s)…….

* Surname……..……

* Date of Birth .....…… * Date You Completed this Form……..

* Town and Country of Birth ..... ……
If London, we need the district.

* Contact telephone number(s)

Home……Business……..……..Mobile……

E-mail address……..……

* Occupation……

Emergency Contact	**Tel**
Address	

* Please tick **one** box below that you feel best describes your ethnic origin:

White British ☐ Any Other White Ethnic Group ☐ Mixed White & Black Caribbean ☐ White & Black African ☐
White & Asian ☐ Any other Mixed background ☐ Asian or Asian British ☐ Any other Asian background ☐
Black or Black British ☐ Any other Black background ☐ Other Ethnic Group ☐

Are you able to consult with the GP in English?

Yes ☐ No ☐

If not what is your main language?.....

Do you have any communication needs? ie BSL, texting, large font, braille Yes ☐ No ☐

* Do You Smoke? ..... Yes ☐ No ☐ If **YES** How many cigarettes / cigars / oz. per day?..... ☐

* **Height & Weight**

Height:		Weight:		Waist:	

Please be as accurate as possible

* **Please circle the answer that best applies to you to each of the following questions**

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking? Standard alcoholic unit = half a pint of beer, a 125ml glass of wine, a measure of spirit each count as one unit.	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

You will need to book a New Patient Check Up with the nursing staff please book at Reception

Personal Medical History

Please specify any major illness or operations with dates

……

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……

……

Have you suffered from

Heart Disease/ Heart Attack?	Y/N	Strokes?	Y/N
Blood Pressure?	Y/N	Diabetes?	Y/N
Asthma?	Y/N	Eczema/hayfever?	Y/N
Epilepsy?	Y/N	Blindness/Glaucoma?	Y/N
Cancer?	Y/N	Depression/ Mental Health?	Y/N

Family Medical History

Has any close relative (parent, brother or sister) suffered from any of the following illnesses:

Family Member	**Age**	**Family Member**	**Age**
Heart Disease/ Heart Attack?	Y/N	Strokes?	Y/N
Blood Pressure?	Y/N	Diabetes?	Y/N
Asthma?	Y/N	Hyperthyrodisim	Y/N
Epilepsy?	Y/N	Chronic Bronchitis or Emphysema	Y/N
Cancer?	Y/N	Depression/ Mental Health?	Y/N

Any other inherited disease ……..……..

Please list any hospital admissions with the reason and approximate date:……....
……

Drugs and Medicines

Please list ALL prescribed medicines that you take regularly (including the contraceptive pill.)

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_____

Are you ALLERGIC to any medicines? Yes ☐ No ☐ If yes which ones?

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* **Female Patients Only**

Have you had a Cervical Smear Test within the past 3/5 years Yes ☐ No ☐ Date .....

Was it Normal? Yes ☐ No ☐

Where was it done? GP / Hospital / Family Planning Clinic / Abroad / Other .....

Have you had a hysterectomy? Yes ☐ No ☐

If **YES**, was it because of cancer? Yes ☐ No ☐

Have you had a mammogram? Yes ☐ No ☐ If yes, when?
