Adult

New Patient Registration/Health Questionnaire

To the patient:

To register with the practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Please note if you are on any repeat medication you will need to be seen by the GP first.

Surname: ..... Forename(s): .....

Date of birth: ..... Marital status: .....

Address:

.....

..... Postcode: .....

E-Mail address: .....

Occupation: .....

Home Tel: ..... Mobile: .....

Weight (approx): ..... Height: .....

Date of completion of this form: .....

Smoking:

Do you smoke? Yes/No

If yes, how many:
Cigarettes per day ..... Cigars per day ..... Ounces of tobacco per day .....
How old were you when you started smoking? .....

Ex-Smokers:

How old were you when you stopped smoking? .....
How much did you smoke per day? .....

Passive smoking:

Are you exposed to smoke at work? Yes/No At home? Yes/No

Medication

Please give details of any medication which you take (prescribed of otherwise):

Name of drug: .....
Dosage: .....

Name of drug: .....
Dosage: .....

Name of drug: .....
Dosage: .....

Allergies:

Are you allergic to any substances or foods? Yes/No

If yes, please give details:

.....
.....

Past Medical History:

Please give details of any hospital treatment as an in-patient:

.....

Please give details of any treatment for any chronic medical conditions:

.....

Please give details of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

.....

Immunisations:

Dates of Triple/polio/HIB: .....
Dates of MMR: .....
Date of last Tetanus: .....

Female Patients:

Date of most recent smear: .....
Result of most recent smear: .....
Please give details of any complications in pregnancy:

.....

Diet:

Do you add salt to your food after cooking? Yes/No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No

Has your Cholesterol been checked in the last 2 years? Yes/No

Exercise:

Do you take regular exercise? Yes/No

If yes, what sort of exercise? .....
How many times per week? .....

Family History:

Is there any of the following in your family (*father, mother, brother, sister)* before the age of 65?

Heart disease (heart attacks, angina) Yes/No Which family member? .....
Stroke? Yes/No Which family member? .....
Cancer? Yes/No Which family member? .....
Site of cancer? .....

Ethnicity

Language: ..... Interpreter: Yes/No
Ethnicity: .....

Carers

Do you need/have anyone who looks after you or your daily needs as carer? Yes/No
If 'yes', would you like them to deal with your health affairs here? Yes/No
(the receptionist can help you with these arrangements)

Do you care for anyone else? Yes/No
If 'yes', ask the receptionist about carers support

Next of kin details:

Name: ..... Relation: .....

Contact number: .....

Thank-you for completing this questionnaire