New Patient Questionnaire

Today's Date: _____

Surname _____ **Previous Surname(s)** _____

Forenames _____ **Marital Status** _____

Date of Birth _____ **Occupation** _____ **Work tel. no.** _____

Telephone no. Home: _____ **Mobile no.** _____

Next of kin (name and contact phone no.) _____

Other family members at the same address _____

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

A. White	**B. Mixed**	**C. Asian or Asian British**	**D. Black or Black British**	**E. Chinese or other ethnic group**
☐ British	☐ White + Black Caribbean	☐ Indian	☐ Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Pakistani	☐ African	☐ Any other
☐ Other (write in)	☐ White and Asian	☐ Bangladeshi	☐ Any Other Black background	
……	☐ Any Other Mixed	☐ Any Other Asian	(write in) ……	……

Carers: Do you look after someone or does someone regularly help you? (please give details)

_____

Height: _____ **Weight:** _____

Do you smoke? (please tick)
☐ Yes - _____ daily (please indicate number)
☐ No - given up when? _____ how much did you used to smoke? _____
☐ No - Never smoked

How much alcohol do you drink per week? _____ units
(1 unit = 1 small glass of wine / 1 single spirit / half pint beer)

Please list any allergies to medication _____

How often do you exercise? _____ per week. What type of exercise? _____

What type of diet do you have?-please circle:-

mixed diet / unhealthy / vegetarian / low fat / diabetic / other- please specify _____

Operations, Major illnesses and Medical Conditions + date / year (continue overleaf if necessary)

_____

_____

_____

Repeat Medication Please list name, dose, and no. of times it is taken daily:

_____

_____

_____

Tetanus- date of last booster _____

Family History Do you have parents, brothers or sisters who have had any of the following?

Diabetes _____ Heart Attack _____
Bowel cancer _____ Heart Attack under the age of 60 _____
Breast cancer _____ Thyroid disorder _____
Stroke _____ Any other important family illness _____

Women Only: **Method of contraception** if used _____

Date of last smear _____ result? _____

Date of mammogram if applicable _____

Please list any pregnancies _____

_____

Thank you for completing this form