EDENFIELD ROAD SURGERY

NEW PATIENT QUESTIONNAIRE – CONFIDENTIAL

Please complete one questionnaire for each person intending to join the Practice. The information will be retained in your medical records.

Surname: _____ Maiden Name: _____

Forenames: _____ Marital Status: _____

Date of Birth: _____ Telephone No: _____

Address: _____

Email:_____ Post Code: _____

Gender Male/Female

ETHNIC GROUP (which of the following ethnic group do you fall into?) Please circle one.

British/Mixed	White or Black Caribbean	Indian/British
Irish	White or Black African	Pakistan/British
Other White	White Asian	Bangladesh/British
Chinese/Other		

MAIN LANGUAGE SPOKEN

English	Punjabi	Urdu
Bengali	Hindi	Kurdish
Arabic	Polish	Other

P.T.O

PAST MEDICAL HISTORY

Please Circle and add date of diagnosis if you have had any of the following, and mark with the letter 'F' if they run in your family:

DATES:

Asthma

COPD (Chronic Bronchitis or Emphysema)

High Blood Pressure

Heart Failure

Atrial Fibrillation

Stroke/TIA

Angina

Heart Attack

Coronary Angioplasty

Coronary Bypass Operation

Type 1 Diabetes

Type 2 Diabetes

Gestational Diabetes

Kidney Failure

Chronic Kidney Disease

Depression

Other Mental health Problems (please specify)

Cancer (please specify)

Epilepsy

Learning Difficulty

Hypothyroidism

Dementia

Any Operations (please specify and dates)

Have you had a flu vaccination? Y/N If so, please enter date of last one:_____ or circle NEVER

Have you had a pneumonia vaccination? Y/N If so, please enter date of last one:_____ NEVER

Do you have any allergies?

_____

Social History – What is your occupation?

Smoking History (please circle) Never Smoked
Ex- Smoker
Current Smoker

Weekly Alcohol intake _____ units per week

MEN How often would you have EIGHT or more drinks on the same day?

WOMEN How often would you have SIX or more drinks on the same day?

What is your Height? _____ What is your weight? _____

Medication – Please list all medicines /tablets etc, or attach a copy of a recent prescription list from your previous GP.

_____
_____
_____

Date of last smear (women) _____

Thank you for filling in this form. The information will help us to provide you with better and more appropriate care, with regular follow-up as necessary.

Please provide details of your next of kin

Surname:	Forename:	Tel No:
Surname:	Forename:	Tel No:

Children under 18

Surname: All Previous Surnames:

Forenames: D.O.B

Current School/Nursery:

ALL NEWLY REGISTERED CHILDREN UNDER THE AGE OF 18 ARE ENTITLED TO A NEW PATIENT CHECK

Do you require this? YES/NO (Please circle). If yes, please make an appointment with the Practice Nurse once you are registered.

Please name all adults over 18 living at the same address

Surname: Forename: D.O.B

Surname: Forename: D.O.B

Surname: Forename: D.O.B

Surname: Forename: D.O.B

Surname: Forename: D.O.B

MILITARY VETERANS

Are you a Military Veteran? (Please circle)

Yes No

Do you agree to this being recorded in your medical records? (Please circle)

Yes No

Signature: _____ Date: _____