NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Dear Patient,

Welcome to the Thorndike Surgery.

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 could you answer the following questions and return the form to the surgery before your first appointment so that information can be entered on the computer, as it can take sometime for your records to be transferred to the surgery.

Please book your new patient health check with reception allow one week. If you are on repeat medication you will require a doctor's appointment if you would like a combined doctors/nurses appointment to save a return trip this may take longer than a week to organise.

If you have any children under 5 years, please bring your red record book with you.

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

Date of Birth: …………………………………………….. Marital status: ….……………………………

Address: ………………………………………………………………………………………………………

……………………………………………………………Postcode: ……………………………..….

Home tel: …………………………Mobile: ………………………Work tel:………………………………

Carers details if applicable: Name:…………………………… Telephone:………………………

Email address: ………………………………………………………………………………………

Occupation: ……………………………………………………………………………………………

Ethnicity

White British		Black Other		Black African	
White Other		Occupational Traveller		Black Caribbean	
Asian Indian		Gypsy Traveller		Not disclosed	
Asian Pakistani		Asian Chinese		Other	
Asian Bangladeshi		Asian Other		If 'other' please spec	

Religion (please specify)……………………………………………………………….

Spoken Language (please specify)……………………………Do you requite a translator? Yes / No

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?		
Would you like advice on how to quit? Yes / No		
EX SMOKER		
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	

ALCOHOL
For the following questions please circle the answer which best applies
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits
Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?
Never Less than monthly Monthly Weekly Daily or Almost Daily
How often during the last year have you been unable to remember what happened
the night before because you had been drinking?
Never Less than monthly Monthly Weekly Daily or Almost Daily
How often during the last year have you failed to do what was normally expected
of you because of drinking?
Never Less than monthly Monthly Weekly Daily or Almost Daily
In the last year has a relative or friend, or a doctor or other health worker been
concerned about your drinking or suggested you cut down?
No Yes on one occasion Yes on more than one occasion

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?

MEDICATION

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

Medication	Dose	Why are you taking this medication
e.g. Atenolol	50	High blood pressure

Family History/Medical Conditions/ Allergies/ Operations/ Immunisations

Name	Date Diagnosed	Operations	Date of Procedure
Asthma			
Blood Pressure			
Angina			
Thyroid Problems		**Allergies**	**If yes please detail**
Stroke		Yes / No	
Diabetes			
Epilepsy		**Female Patients**	**Date or Details**
Glaucoma		Recent Cervical Smear	
Immunisations	**Date Given**	Result	
Triple/Polio/HIB		Complications in pregnancy?	
MMR		Do you have a coil fitted?	
Tetanus		Would you like contraceptive advice?	Yes / No
		Breast Screening	
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?	
Alzheimer/Dementia	Yes/No		

Any additional information that you feel will help the Doctor:…………………………………………………………….

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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 with these arrangements)

Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.

Signed:

Dated:

Staff Check List

Practice Booklet		New Patient Check Booked:	Date:
Doctors Appointment (if needed) Date:		Sample Bottle Given	Yes / No
Checked By:	Signed:		
	Print Name:		
Data Entry	Name:		Date: