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|  | **The Thorndike Surgery**  Thorndike Surgery Logo |  |

**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. Please bring two forms of identification with you, i.e. household bill, driving licence or passport. The information in the questionnaire will help the doctor to make an initial assessment of your health this will help with future treatment. Once completed please return the questionnaire to the surgery before your first appointment.

Please book your new patient health check appointment with reception. If you are in repeat mediation you will also require an appointment with a doctor. We can book both appointments together if this is more convenient however this may take a little longer to arrange.

If you have a child under 5 years of age please bring your red book with you.

Please note for all patients who are not ordinarily resident in the UK you may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment

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

Date of Birth: …………

Marital status: ….………………………… Previous Surname: .………………………………………………………..

Address: …………………………..………………………………………………………………………………………………………

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

Home tel: ………………….…………..……………………..……

Mobile: …………...………………………………….…..…

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

Occupation: ………………………………………………………………………………………………………………………….….

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

Date of completion of this form: ……………………

**Ethnic Origin**

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

**Choose ONE section from A to E, and then tick ONE box to indicate your background.**

A White

|  |  |
| --- | --- |
|  | British |
|  | Irish |
|  | Any other white background, please state: |

B Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background, please state: |

C Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background, please state: |

D Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | Any other black background, please state: |

E Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other, please state: |

|  |
| --- |
|  |

First language:

**Smoking**

Do you smoke? *Yes* / *No*

If *Yes*, how many…: Cigarettes 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 passive smoke at work? *Yes* / *No* At home? *Yes* / *No*

**Alcohol**

For the following questions please circle the answer that best applies:

**One drink = 1/2 pint of beer/one glass of wine/one single measure of 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/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/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/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?

*Yes No*

**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 two years? *Yes* / *No*

**Exercise**

Do you take regular exercise? *Yes* / *No*

If yes, what sort of exercise? ……………………………………………………………….

How many minutes do you typically spend exercising per session? …………

How many times do you exercise per week? ……..

**Family History**

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

Heart Disease (e.g. heart attacks, angina) *Yes* / *No* which family member? ………………………….

Stroke *Yes* / *No* which family member? ………………………….

Cancer *Yes* / *No* which family member? ………………………….

Site of cancer? ……………………………………………………

**Medication**

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

Name of drug: ……………………………………

Dosage: …………………………………………….

Name of drug: ……………………………………

Dosage: …………………………………………….

**Allergies**

Are you allergic to any substances, including medication or foods? *Yes* / *No*

If *Yes*, please give details:

………………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………

**Past Medical History**

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

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……………………………………………………………………………………………………………………………………

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

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Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound:

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**Immunisations**

Dates of triple/polio/HIB: ……………………………………………………………………………………………..

Dates of MMR: ……………...……………………………………………………………………………………………..

Date of last Tetanus: …………………………………………………………………………………………………….

**Female Patients**

Date of most recent cervical smear: ………………………………..

Result of most recent smear: …………………………………

Please give details of any complications in pregnancy:

……………………………………………………………………………………………………………………………………

**Carers**

Does someone look after you? Or do you need / have anyone who *Yes* / *No*  
looks after you or your daily needs as a Carer?

If *Yes*, would you like them to deal with your health affairs here? *Yes* / *No*

**The receptionist can help with these arrangements**

Do you look after someone else? *Yes* / *No*

**If *Yes*, please ask the receptionist about Carers support**

**General**

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below: