

## New Patient Questionnaire

### Welcome to Guildhall Walk Healthcare Centre

This questionnaire has been designed to help your new GP get to know you and your medical history. The information you provide will be handled confidentially by your GP but if you are concerned about any of the questions please leave them blank. A member of staff will be happy to discuss any queries you have.

#### PERSONAL DETAILS:

Title:		Address:	
Surname:			
Forename:			
D.O.B:			
Home Tel:			
Mobile Tel:		Postcode:	
Work Tel:		Occupation:	
Status:	Single   Married   Separated   Divorced   Widowed In Relationship		
Sexual Orientation:			Do not wish to disclose
Next of Kin:	Relationship:	Contact Tel No:	
Address:			

#### DETAILS OF PREVIOUS GP:

Practice Name		
Address:		
Street		
Town / Post Code		
Telephone Number		
Usual Doctor		
Approximately how long were you registered with this practice?		

**PLEASE COMPLETE FOR ALL PATIENTS UNDER 16 YEARS:**

Accompanied today by:	
Name of school:	

**ETHNICITY: Please tick one of the following**

<p><b>Asian or Asian British</b></p> <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Other Asian background Please State:	<p><b>Mixed</b></p> <input type="checkbox"/> White & Asian <input type="checkbox"/> White and Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background Please State:	<p><b>Other Ethnic Group</b></p> <input type="checkbox"/> Chinese <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Any other ethnicity Please State:  <input type="checkbox"/> I do not wish to disclose my ethnic origin
<p><b>Black or Black British</b></p> <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Other Black background Please State:	<p><b>White</b></p> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background Please State:	<p><b>First spoken language:</b></p>

**GENERAL HEALTH INFORMATION.**

Height:	Weight:	Blood Pressure:

**DISABILITY:**

	YES/NO	If so, please give details?
Do you have a disability or long term condition?		
Do you have a carer?		
Are you a carer?		

**PAST MEDICAL HISTORY:**

	YES/NO		YES/NO
Heart Disease		Epilepsy	
Stroke		Mental Illness	
Diabetes		HIV	
High blood pressure		Thyroid	
Asthma		Other	
Previously been in hospital? (Date & Diagnosis)			
Known Allergies			

**FAMILY HISTORY: (Parents, brothers & sisters)**

	YES/NO	If yes please give brief details	Age at first occurrence	
			Under 60	Over 60
Heart Disease				
Stroke				
High blood pressure				
Diabetes				
Breast Cancer				
Ovarian Cancer				
Bowel Cancer				
Other				

**SMOKING:**

<input type="checkbox"/> I am a current smoker	How many per day
<input type="checkbox"/> I have never smoked	
<input type="checkbox"/> I am an ex-smoker	Approximate Date of Giving Up

**ALCOHOL:**

On average, how many units of alcohol a week do you drink per week? (1 unit = half pint beer, 1 glass wine, 1 spirit shot)	
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**EXERCISE:**

In an average week how often do you exercise?		
<input type="checkbox"/> No regular exercise	<input type="checkbox"/> More than twice a week	<input type="checkbox"/> Once or twice a week

**WOMEN:**

Are you on any form of contraception? If so, please state:			
Date of most recent cervical smear:		Result of smear:	
If age 50-65, date of last mammogram:		HPV vaccinations:	

**CURRENT MEDICATIONS:**

Taking medication:	€Yes	€No	Allergic to medication:	€Yes	€No
Details:			Details:		

**HOW DID YOU FIND OUT ABOUT THIS PRACTICE?:**

<input type="checkbox"/> Referred by my GP  <input type="checkbox"/> Recommended by a friend/relative  <input type="checkbox"/> Chosen on NHS Choices	<input type="checkbox"/> Website/Search Engine  <input type="checkbox"/> Local Promotion/Information Leaflet  <input type="checkbox"/> Advertisements....(Please specify)
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**FOR OFFICE USE ONLY**

Proof of Identity	<input type="checkbox"/> Passport <input type="checkbox"/> Driving licence <input type="checkbox"/> Identity card <input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill <input type="checkbox"/> Tenancy Agreement <input type="checkbox"/> Bank Statement <input type="checkbox"/> Other