Fig Tree Medical Practice - NEW PATIENT QUESTIONNAIRE - STRICTLY CONFIDENTIAL

This information will be recorded on your medical records and will help us to provide your medical care.

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| --- | --- | --- | --- | --- | --- |
| **Full Name:** | | | **Previous Surname:** | | **Date of birth:** |
| **Full Address:** | | | Contact telephone numbers:  C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngHome:  C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngMobile:  C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngWork:  C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngEmergency contact**:**  **Do you consent to receiving text message reminders?**  YES/NO | | |
| **Name and address of your previous GP:** | | | | | |
| **Sexual orientation: Which of the following best describes how you think of yourself:**  Homosexual Straight  Gay or Lesbian Bisexual  In another way (please state): | | | **Gender Identity and Trans Status Monitoring**   * Woman (including trans women) * Man (including trans man) * Non-binary * In another way (please state): * Is your gender identity the same as the gender you were given at birth? YES/NO | | |
| **Occupation:** | **Religion:** | | **Next of Kin:** | | **Marital Status:** |
| **Ethnicity**: | | **Preferred spoken language:** | | **Do you need an interpreter?**  YES / NO | |
|  | | | **If yes, please provide details:** | | |
| Do you have any current medical conditions? | | | YES / NO | | |
| Do you have any allergies? | | | YES / NO (If yes please list) | | |
| Are you a Carer for someone? | | | YES / NO | | |
| Are you a Foster Carer? | | | YES / NO | | |
| Do you have a Carer? | | | YES/NO (If yes, please provide a contact name and  number) | | |
| Are you a Military Service Veteran? | | | YES / NO | | |
| **Females Only:**  Are you pregnant? YES / NO If yes, when is your due date?  How many children do you have? | | | **Names and date of birth of Children:** | | |
| When was your last smear test? | | |  | | |
| **Do you take any regular medicines?**  YES / NO (If yes, please list all medicines and dosage or attach a copy of your repeat prescription) | | | | | |
| **Please tick your current smoking status:**  Smoker Ex-smoker Never smoked  If you are a smoke – how many do you smoke each day? | | | | | |
| **Please answer all 3 questions:**  **How often do you have a drink containing alcohol?**  N/A NEVER MONTHLY OR LESS 2-4 A MONTH 2-3 A WEEK 4+ WEEKLY  **How many units do you drink on a typical day when you have a drink?**  N/A 1-2 3-4 5-6 7-9 10+  **How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?**  N/A Never Less than monthly Monthly Weekly Daily or almost daily  \\SERVER\Home\manager\Desktop\units 2.png | | | | | |
| **Additional information:** | | | | | |
| **If you would like to register for online services, allowing you to make appointments and order your prescriptions online, please provide an email address:**  **Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

Please make an appointment for a New Patient Health Check and please bring a urine sample along with you. Patients over the age of 40 may require a blood test.

The Practice will automatically create a summary care record for you, if you would like to find out more or opt out of this, please let the receptionist know.