NEW PATIENT QUESTIONNAIRE - STRICTLY CONFIDENTIAL

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

Full Name:	**Previous Surname:**	**Date of birth:**

Full Address:	Contact telephone numbers: ☎Home ☎Mobile ☎Work ☎ **Emergency contact** **Do you consent to receiving text message reminders?** YES/NO Email address (if available):
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
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)

Which Chemist would you like to nominate to receive your prescriptions electronically?

Please tick your current smoking status:	**Height:**
• Smoker • Ex-smoker • Never smoked If you would like help with stopping smoking please ask your local Pharmacy	**Weight:**

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

Additional information:

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 will require a blood test.