

## NEW PATIENT QUESTIONNAIRE - STRICTLY CONFIDENTIAL

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

<b>Full Name:</b>		<b>Previous Surname:</b>		<b>Date of birth:</b>	
<b>Full Address:</b>		Contact telephone numbers: ☎ Home ☎ Mobile ☎ Work ☎ <b>Emergency contact</b> <b>Do you consent to receiving text message reminders?</b> YES/NO  Email address (if available):			
<b>Sexual orientation: Which of the following best describes how you think of yourself:</b> <ul style="list-style-type: none"> <li>• Homosexual</li> <li>• Straight</li> <li>• Gay or Lesbian</li> <li>• Bisexual</li> <li>• In another way (please state):</li> </ul>		<b>Gender Identity and Trans Status Monitoring:</b> <ul style="list-style-type: none"> <li>• Woman (including trans women)</li> <li>• Man (including trans man)</li> <li>• Non-binary</li> <li>• In another way (please state):</li> <li>• Is your gender identity the same as the gender you were given at birth? YES/NO</li> </ul>			
<b>Occupation:</b>		<b>Religion:</b>		<b>Next of Kin:</b>	
<b>Marital Status:</b>		<b>Ethnicity:</b>		<b>Preferred spoken language:</b>	
				<b>Do you need an interpreter?</b> YES / NO	
		<b>If yes, please provide details:</b>			
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			
<b>Females Only:</b> Are you pregnant? YES / NO If yes, when is your due date?  How many children do you have?		<b>Names and date of birth of Children:</b>			
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:**

- Smoker
- Ex-smoker
- Never smoked

If you would like help with stopping smoking please ask your local Pharmacy

**Height:**

**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.**

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.