**New Patient Questionnaire – Adults (16+)**

**If written, please use capitals in black ink**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details** | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Title | |  | | | | | | | | | | | | Gender | | | | | | | | |  | | | | | | | | | | | | | | | | |
| First name | |  | | | | | | | | | | | | Known as | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Middle name/s | |  | | | | | | | | | | | | NHS number | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Surname | |  | | | | | | | | | | | | DOB (dd/mm/yyyy) | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Previous surname | |  | | | | | | | | | | | | Town & country of birth | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Marital status | |  | | | | | | | | | | | | Occupation | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | Number of children | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Home tel number | |  | | | | | | | | | | | | Mobile tel number | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Work tel number | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Email address | |  | | | | | | | | | | | | | | | | | | | | | Preferred contact method | | | | | | | | | | | | |  | | | |
| Next of kin (name) | |  | | | | | | | | | | | | Relationship to you | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Next of kin tel no | |  | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |  | | | | | |
| Your first language | |  | | | | | | | | | | | | Interpreter required | | | | | | | | | Yes | | | | | | | | | | | | No | | | | |
| **Previous GP** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous GP name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Addresss | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| White British | | | |  | | | | | | | | | | Asian Chinese | | | | | | | | | | | | | | | |  | | | | | | | | | |
| White Irish | | | |  | | | | | | | | | | Asian Indian | | | | | | | | | | | | | | | |  | | | | | | | | | |
| White other (please state) | | | |  | | | | | | | | | | Asian Pakistani | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | |  | | | | | | | | | | Asian other (please state) | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Black African | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Black Caribbean | | | |  | | | | | | | | | | Mixed White & Asian | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Black other (please state) | | | |  | | | | | | | | | | Mixed White & Black African | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | |  | | | | | | | | | | Mixed White & Black Caribbean | | | | | | | | | | | | | | | |  | | | | | | | | | |
| I do not wish to state | | | |  | | | | | | | | | | Mixed other (please state) | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |
| **Medical history** | | | | **Have you or anyone in your family suffered from any of the following conditions?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Self | | Family | | | | | Who? | | | | | |  | | | | Self | | | | | | | Family | | | | | | | Who? | | | | | | | |
| Asthma |  | |  | | | | |  | | | | | | Diabetes | | | |  | | | | | | |  | | | | | | |  | | | | | | | |
| Cancer |  | |  | | | | |  | | | | | | Heart attack | | | |  | | | | | | |  | | | | | | |  | | | | | | | |
| High blood pressure |  | |  | | | | |  | | | | | | Stroke | | | |  | | | | | | |  | | | | | | |  | | | | | | | |
| Other conditions? |  | | | | | | | | | | | | | Date | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Other conditions? |  | | | | | | | | | | | | | Date | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Lifestyle** | |  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Alcohol Screening Questions | | | | | | | 0 | | | | 1 | | | | | 2 | | | | | | | | | | 3 | | | | | | | | | | | | 4 | |
| How often do you have a drink containing alcohol? | | | | | | | Never | | | | Monthly or less | | | | | 2-4 times a month | | | | | | | | | | 2-3 times a week | | | | | | | | | | | | 4 or more times a week | |
|  | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | | | | | | | 1 or 2 | | | | 3 or 4 | | | | | 5 or 6 | | | | | | | | | | 7 or 8 | | | | | | | | | | | | 10 or more | |
|  | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | | | | | | | Never | | | | Less than monthly | | | | | Monthly | | | | | | | | | | Weekly | | | | | | | | | | | | Daily or almost daily | |
|  | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | |
| How often during the last year have you failed to do what was normally expected of you because of your drinking? | | | | | | | Never | | | | Less than monthly | | | | | Monthly | | | | | | | | | | Weekly | | | | | | | | | | | | Daily or almost daily | |
|  | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | |
| Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down? | | | | | | | No | | | |  | | | | | Yes, but not in the past year | | | | | | | | | |  | | | | | | | | | | | | Yes, during the last year | |
|  | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | |
| Have you ever smoked? | | | | | Yes  No | | | | | | If you have stopped, please write when | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Do you currently smoke? | | | | | Yes  No | | | | | | How many do you smoke a day? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | |  | | | | | | How long have you been a smoker? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Do you regularly exercise? | | | | | Yes  No | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| What is your height? | | | | |  | | | | | | What is your weight? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Females only** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had a smear test in the last 3 years? | | | | | | | | | Yes  No | | | | Are you pregnant? | | | | | | | Yes  No | | | | | | | | | | | | | No of weeks | | | | | |  |
| What was the date of your last smear test? | | | | | | | | |  | | | | What was the result of the test? | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Do you attend a family planning clinic? | | | | | | | | | Yes  No | | | | Where? | | | | | | Hospital | | | | | | | | | | | | | | Private clinic | | | | | | |
| Do you use contraception? | | | | | | | | | Yes  No | | | | Which method? | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Have you ever been pregnant? | | | | | | | | | Yes  No | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Please state the number of | | | | | | Live births | | | |  | | Miscarriages | | | | |  | | | | | | | | | | Terminations | | | | | | | | | |  | | |
| I have read the practice website. I understand how to access the service at the Practice. I agree to follow the guidelines and behave appropriately. I am aware that rudeness and aggressive behaviour are not tolerated and will result in removal. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | |  | Date |  |
|  | | | | | |  | | | |  | |  | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | |
| Please provide a proof of address no older than 3 months; typically a bank statement, rent agreement, utility bill (but not mobile phone bill), council tax or HRMC letter. Please also provide photo ID; typically your passport, driving license or freedom pass. We will take the relevant photocopies.  **If you wish to book appointments and order repeat prescriptions online please register with reception. For more details please go to our website** [**www.theredcliffesurgery.co.uk**](http://www.theredcliffesurgery.co.uk) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |