**THE LONDON ROAD SURGERY**

**NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE**

**Please complete this Form. Parents/Guardians should complete the appropriate sections on behalf of children**

**Registration cannot be completed unless all information supplied is validated**

**DATE QUESTIONNAIRE COMPLETED: ………………………………………………….……………**

|  |  |
| --- | --- |
| **SURNAME** |  |
| **FORENAME(S)** |  |
| **ADDRESS** |  |
| **TELEPHONE** **NUMBERS** | **HOME:**  |
| **MOBILE:**  |
| **EMAIL ADDRESS:** |  |
| **DATE OF BIRTH** |  | **AGE** |  |
| **SEX** |  | **MARITAL STATUS** |  |
| **OCCUPATION** |  |
| **NAME & ADDRESS OF LAST GP** |  |
| **WHY DID YOU LEAVE YOUR LAST GP?** |  |

**MEDICAL HISTORY**

1. Any serious illness: **………………………………………………….……………**

1. Any illness that prevents

 you from working **………………………………………………….……………**

3. Operations or injuries: **…………………………………………………….…………**

4. Allergies (inc medicines) **……………………………………………………….………**

5. Do you take regular medication? YES/NO

6. **PLEASE LIST YOUR MEDICATION** **…………………………………………………….………**

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**Do you suffer from any of the following?**

DIABETES YES/NO

If so, are you Insulin dependent? YES/NO

Which Insulin do you have? **……………………………………………………..………**

Do you attend a diabetic clinic? YES/NO

At: Hospital □ Surgery □ Both □

ASTHMA YES/NO

Have you been admitted to Hospital for this? YES/NO

If YES, when: **……………………………………………………….……**

ANY CHEST PAIN AFTER EXERTION? YES/NO

ANY HISTORY OF HEART ATTACK? YES/NO

ANY HISTORY OF STROKE? YES/NO

Do you have any family history of the following?

ANGINA □ Which Relative? **……………………………….……..**

HEART ATTACKS □ Which Relative? **…………………………….………..**

HIGH BLOOD PRESSURE □ Which Relative? **…………………………….………..**

STROKES □ Which Relative? **……………………………….……..**

ASTHMA □ Which Relative? **……………………………….……..**

DIABETES □ Which Relative? **………………………….…………..**

CANCER □ Which Relative? **………………………….…………..**

How many units of alcohol do you take in a week? **…………………………….……….**

(1 unit = half a pint, or 1 pub measure of wine or spirits)

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Do you smoke? YES/NO

If YES, number per day **…………….** Number of years smoked **…………...………..**

Are you an EX SMOKER? YES/NO

Year stopped **…………….** Number smoked **……………………..**

Do you think your diet is healthy? YES/NO

What exercise do you take? **…………………………………………..……….………**

What is your approximate WEIGHT **……..……...….**  HEIGHT **……….....…….**

ADULTS

When was your last tetanus booster? **………………………..…………………………...……..**

FEMALES

Approximately when did you have your last cervical smear? **…………………………………..…..**

Are you currently pregnant? YES/NO

Hysterectomy? YES/NO Date & Place **…………………………………..…..**

Do you use contraception? YES/NO What type **…………………………..….…..…..**

**CARERS**

As a surgery, we need to identify whether a patient has a carer or is indeed a carer themselves to enable us to meet all their needs.

Do you have a carer? YES/NO

If YES, please give details. **…………………………………………………..………….**

Are you a carer of another registered patient? YES/NO

If YES, please give details of dependant

and nature of their disability. **…………………………………………………..………….**

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**ETHNICITY**

Please read the list below and tick the appropriate box that you feel most nearly describes your ethnic origin.

WHITE

 ❑ British ❑ Any other white background

MIXED

 ❑ White & Black ❑ White & Asian ❑ White & Black ❑ Any other mixed

 Caribbean African background

BLACK OR BLACK BRITISH

 ❑ Caribbean ❑ African ❑ Any other black background

ASIAN OR ASIAN BRITISH

❑ Indian ❑ Pakistani ❑ Bangladeshi ❑ Any other Asian background

 ❑ Vietnamese ❑ Chinese ❑ Other Ethnic Group (please specify)

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PREFER NOT TO SAY ❑

|  |
| --- |
| **THE SURGERY MAY WISH TO CONTACT YOU USING EMAIL OR TEXT MESSAGING.****If you wish to opt out of this service please circle OPT OUT** |