NEW PATIENT INFORMATION QUESTIONNAIRE
CONFIDENTIAL

To complete the registration process, ALL new patients are seen by the Healthcare Assistant for a New Patient Update

PLEASE WRITE IN BLOCK CAPITALS

PERSONAL INFORMATION

Gender: M / F
Mr / Mrs / Miss / Ms (*circle status*) Date of Birth: ……………………………..............

First Names: ……………………………………... Surname: ………………………………………
Address: ……………………………………….
…………………………………………………
…………………………………………………
Telephone Number:
Home: ………………………………………… Mobile: ………………………………………

Occupation: ……………………………………

Next of Kin: …………………………………... Relationship to patient………………………..
Telephone Number: ……………………………...

Do you wish your next of kin or any significant other to be able to access and discuss your medical information on your behalf? **Yes / No**
If yes, please give details: Name…………………………………………………………………
Relationship…………………………………..Tel no………………..

Other family members at this address
…………………………………………………………
…………………………………………………………
…………………………………………………………
…………………………………………………………

SPECIAL CIRCUMSTANCES

Are there any special circumstances that you would like to bring to our attention? (e.g. social circumstances, housing concerns etc) Yes / No
*If **Yes**, give details:*

Has anyone in the family been known to social care or had a Social Worker? Yes / No
If **Yes**, give details:

LANGUAGE

Is English your first language? **Yes / No**
If **No** state language: ……….........................

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COUNTRY OF ORIGIN ……………………………………………………………………

ETHNICITY

WHITE:
British / Irish / Greek Cypriot / Turkish / Kurdish
Other *please specify*: ……………………………

ASIAN or ASIAN BRITISH:
Indian / Pakistani / Bangladeshi / East African Asian
Other *please specify*: …………………..................

BLACK:
Caribbean / African / Black British
Other *please specify*………………………………

MIXED:
White & Black Caribbean / White & Black African
White & Asian / Other *please specify*……………

CHINESE: Chinese / Other ethnic group: *please specify*:………………………………….

I would prefer not to answer [ ]

HEALTH

Your **Height**: Your **Weight**: Your **Blood Pressure**:
(Please use the patients' height/weight/BP machine in the waiting area)

Do you / or have you ever smoked?
Smoker / Never Smoked / Ex-smoker – date of quitting…………………………

FEMALE PATIENTS

Have you had a cervical smear? **Yes / No**
If **Yes, Year**:………………………**Result**: …………………………….....

Have you had a hysterectomy **Yes / No**
If **Yes, Year**: ………………………………

CARERS

Do you care for someone with a disability or illness? **Yes / No**

If you have a disability / illness:
Do you have a carer? **Yes / No/ Need One**

IMMUNISATIONS

If you are unsure whether your immunisations are up to date, please book an appointment for a consultation with a nurse.

CURRENT TREATMENTS/ILLNESSES

Long term lung disease	Y / N	……………….	Irregular heart beat	Y / N	…………..
Asthma	Y / N	……………….	Diabetes	Y / N	…………..
Heart Disease	Y / N	……………….	Liver disease	Y / N	…………..
High blood pressure	Y / N	……………….	Dementia	Y / N	…………..

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Depression Y / N ………………. Mental Health Issues Y / N …………..

Are you under hospital treatment for any condition? **Yes / No**
If **Yes** give details…………………………………………………

Have you attended A&E in the last year **Yes / No**
If **Yes** give details……………………………………

Are you on any regular medication? ***Yes / No***
*If **Yes**, give details:………………………………..*

<u>If you are on long term medication for any medical condition you will initially need to see a doctor to obtain a prescription.</u>

DATE: ………………………………………...
NAME: ………………………………………..
SIGNATURE: ………………………………...

Staff use only:

Staff Initials…………………
Date…………………………
Registering Dr……………..
Patient address validated ☐
Audit C completed ☐
Audit completed ☐
Brief Intervention Leaflet Given ☐