Deepcar Medical Centre

NEW PATIENT QUESTIONNAIRE

It may be some time before we receive your medical record. In the meantime this questionnaire will give the doctors important information about your medical history and will help us to give you a better service.

Have you been registered with this practice before? ❑ Yes ❑ No	Today's date:

PATIENT INFORMATION

Surname:		❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status: (Please circle one)
Forenames:			Single / Mar / Div / Sep / Wid

Birth date: / /	Sex: ❑ M ❑ F	Place of birth:	Ethnic origin:	Main language spoken:

Address:	Home phone number:	Mobile number:
	Occupation:	Do we have consent to text you? ❑ Yes ❑ No

Next of kin:	Their relationship to you:	Contact Details:

HEALTH INFORMATION

Do you drink alcohol? ❑ Yes ❑ No	If yes, how many units per week?
	If yes, please could you also complete our Alcohol Questionnaire.
Do you smoke? ❑ Yes ❑ No	If yes, how many cigarettes per day?
	If you used to smoke and have now stopped please tell us when you stopped:

Have you had any of the following medical problems:

Arthritis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chronic Bronchitis	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Thyroid Trouble	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No

Do you have a family history of any of the following:

If yes, please state which family member.

Asthma	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
CVA / Stroke	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Heart Disease < 60	❑ Yes	❑ No
Heart Disease > 60	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
Respiratory Disease	❑ Yes	❑ No

Are you registered disabled? ❑ Yes ❑ No	If yes, please explain:

Do you have any medical problems at the moment i.e. are you under the care of a hospital specialist or are you being treated for anything?

❑ Yes ❑ No

If yes, please give details:

MEDICATION		
Please list any tablets / medicines you are taking or attach the right hand side of your previous prescription:		
Name of tablet / medicine	Dose /strength	Daily Amount
Do you have any allergies to any tablets / medicine? ❑ Yes ❑ No If yes, please give details:		

CARERS					
Are you a carer? ❑ Yes ❑ No			If yes, do you care for any of the following:		
Carer of a person with a learning disability	❑ Yes	❑ No	Carer of a person with mental health problems	❑ Yes	❑ No
Carer of a person with chronic disease	❑ Yes	❑ No	Carer of a person with sensory impairment	❑ Yes	❑ No
Carer of a person with physical disability	❑ Yes	❑ No	Carer of a person with a terminal illness	❑ Yes	❑ No
Carer of a person with substance misuse	❑ Yes	❑ No	Carer of a person with alcohol misuse	❑ Yes	❑ No
Other:					

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

This section is to be completed at the first assessment by the Practice Nurse / Health Care Assistant.	
Height:	
Weight:	
BMI:	
Waist Circumference:	
Urinalysis:	