STAFF NAME: ID TYPE PROVIDED:

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire and hand in with your GMS 1 form for registration to the practice, incomplete forms will delay registration.

Applications from children under 5 years of age are processed when their parents/guardians have complied with this.

To avoid any unnecessary delay in informing the Health Authority of your registration application and request for your medical record, you are required to attend the Surgery for a New Patient Health Check within 4 to 6 weeks once registration completed.

Name: _____

Address: _____

_____

_____ Post Code: _____

Daytime Tel. No: _____ Mobile Tel. No: _____

Consent to receive text messages for appointments & reminders: YES / NO

Date of Birth: _____ Present Age: _____

Do you require all clinical data to be withheld from your Summary Care Record ?
YES / NO

Ethnic Origin (Compulsory): _____

Main Language Spoken: _____

Occupation: _____

Next Of Kin:

Family or friend name and tel. number in emergency: _____

Name: _____ Relationship: _____

Telephone Contact (Home &/ Mobile): _____

Address: _____

_____

Do you have a Carer ? YES / NO Are you a Carer to a relative/friend ? YES / NO

Contact Details if not next of kin: _____

Current Smoker (less than 10 a day): _____ Current smoker (more than 10 a day): _____

Ex-Smoker : _____ for _____ years Never Smoked: _____

Have you ever been advised to stop smoking ? YES / NO

STAFF NAME: ID TYPE PROVIDED:

Have you been diagnosed as Diabetic ? YES/ NO

When were you diagnosed with Diabetes ? _____

Is your diabetic care monitored by :

GP _____ Hospital _____ Shared GP/Hospital _____

Have you been diagnosed as Asthmatic ? YES / NO

Have you been diagnosed as COPD ? YES / NO

Relevant Medical History. Please give details including dates of:-

Current Illnesses: _____

Past Illnesses: _____

Operations _____

_____

Allergies _____

Date of last tetanus immunisation (if known): _____

Are you protected against Measles, Mumps & Rubella ? YES / NO Date: _____

Please give dates of pregnancies: _____

Date of last cervical smear test: _____ Result: _____

Date of last mammogram (over 50s): _____ Result: _____

Please indicate whether you have a relative who has, or has had, any of the following conditions: please indicate whether - Father / Mother / Brother / Sister and approx. age of diagnosis. If no family history mark **N/A** in appropriate sections

Asthma: _____ Diabetes: _____

Cardiovascular Disease: _____ Stroke/TIA: _____

Myocardial Infarction (MI): _____ High Blood: _____

Osteoporosis: _____ Stroke: _____

Epilepsy : _____ Fragility fracture: _____

Glaucoma: _____ Dementia: _____

Cancer (and type): _____

Any family history not listed above: _____