

NEW PATIENT QUESTIONNAIRE

FEMALE (Under 65 years old)

Private & Confidential

Surname:

Forenames:

Occupation:

Marital Status:

Date of Birth:

Spouses Occupation:

Address:

Ethnic Origin.....

.....

Tel No (home):

.....Post Code.....

Tel No (work).....

e-mail address:

Tel No (mobile):

Name of contact in case of emergencies:..... Their 'phone no:

Their relationship to you

If you are a carer, whom do you care for?

If you need care, please give the names and contact details of your carer(s):

.....

Would you like to join our Patient Reference Group where we will contact you periodically by email for your opinion about patient services here or in the local NHS: **YES / NO**

Do you have any special communication needs? **YES / NO**

If yes, are you happy for us to share this with other healthcare providers? **YES / NO**

Have you ever served in the UK armed forces? **YES / NO**

Personal Medical History

Do you have or have ever had any of the following illnesses? (Please circle any that apply)

Asthma

Chronic bronchitis

Epilepsy

High blood pressure

Diabetes

Cancer

Heart attack / angina

Stroke / TIA

Thyroid disease

Mental illness

Please enter details of these and any other significant chronic illnesses, operations or disabilities:

Year	Details	Year	Details

Do you Smoke? (Please circle the answer that applies to you) **NEVER** **EX-SMOKER** **STILL SMOKING**

We offer smoke cessation advice and treatment. Do you want help to stop smoking? **YES / NO**

Do you drink alcohol? **NO** / **Occasionally** / **Yes** – how many units a week?

Do you take regular exercise? **NO** / **Little** / **About 30 minutes five times a week** / **More than this**

Diet Please describe your usual diet (e.g. low fat, balanced, diabetic, vegetarian etc)

Please make an appointment to see one of the nurses.

Bring a urine sample with you

Vaccinations

We recommend keeping up to date with **polio** (every 10 years) and **tetanus** (a total of five jabs per lifetime with a booster after a 'dirty' wound).

We run an **influenza** vaccination programme every October for all patients in high risk groups (aged over 65, asthma, diabetes, chronic heart, kidney or liver disease and immunocompromised).

If you are in one of these groups do you wish to be invited for annual 'flu jabs? YES / NO

Well Woman Health Promotion

Have you ever been pregnant? YES / NO If yes, how many times?

Have you had a hysterectomy? YES / NO If yes, when?

Have you ever had a Cervical Smear? YES / NO If yes, date

Done by: GP / Clinic / Hospital

If you would like a smear test, please make an appointment with Sister Sally Davies

Have you ever had a breast x-ray/mammogram? YES / NO Was it normal? YES / NO

Women aged between 50 and 70 will be invited for **Mammography** screening every three years

If you use contraception, please tick the method used:

Contraceptive pill Which one?For how long?

Cap When was it last checked?

Coil When was it fitted?

We like to review patients taking the contraceptive pill every six months.

Drugs & Medicines (If you are taking any medicines or have an ongoing condition please make an appointment with the doctor after your nurse appointment)

Are you taking any drugs, medicines or tablets? NO YES If yes: (Add last prescription order)

Name of the medicine	Dose	Reason for taking

Allergies Are you allergic to any tablets or substances NO YES If Yes, please give details

Substance you are allergic to	Nature of the reaction (e.g. rash, collapse, swelling etc)

Family History Please indicate if any relatives have suffered from any of the following conditions

Condition	NO	YES	Who & details
Cancer			
Diabetes			
Asthma			
Heart Disease			
Stroke			
Other significant disease			

Signature: Date:

Please make an appointment to see one of the nurses.

Bring a urine sample with you