NEW PATIENT QUESTIONNAIRE

MALE (Over 65 years old) **Private & Confidential**

Surname: …… Forenames: ……..

Occupation: …….. Marital Status: …… ……

Date of Birth: …….. Spouses Occupation: ……

Address: ……

Post Code…… Ethnic Origin……..

Tel No (home): ……..

Tel No (work)……..

E-mail: …….. Tel No (mobile): ……

Would you like to join our virtual 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

Name of contact in case of emergencies:……

Their relationship to you …… Tel no: ……..

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

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

……

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

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 MINS 5 TIMES A WEEK / MORE THAN THIS**

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

Please make a new patient appointment with one of the nurses. Bring a urine sample with you

Well Man Health Promotion

Have you had a prostate check (examination or blood test)? YES / NO

If you have had a previous check and wish to continue please see the practice nurse for a PSA blood test and then the doctor a week later to discuss the results.

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? **YES / NO** If **YES**: (Add last prescription order)

Name of the medicine	Dose	Reason for taking

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

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

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 September/October for all patients aged over 65. We recommend that you have this annual vaccination.

Do you wish to be invited for an influenza vaccination in the autumn? YES NO

If you are over 65 we recommend a one off vaccination against **Pneumococcal pneumonia (Pneumovac).**
Have you had a Pneumovac already? YES / NO

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

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

Signature: …… Date: ……..