NEW PATIENT QUESTIONNAIRE

MALE (Under 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)……

Email: …… 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? ……..

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.

We also recommend regular testicular self-examination.

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 **NO YES** 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 October / November for all patients in high risk groups (asthma, chronic bronchitis, diabetes, chronic heart, kidney and liver disease and those immunocompromised).

If you are in a high-risk group do you wish to be invited for an influenza vaccination? **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: ……

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