NEW PATIENT QUESTIONNAIRE

FEMALE (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)……..

E-mail: …….. Tel No (mobile): …….

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

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? …….

(*please fill out the attached more detailed questionnaire*)

Do you take regular exercise? **NO / LITTLE / ABOUT 30 MINUTES 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 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 are due for 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 t**ick** 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? **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)

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