Drs M Adnan and P Richardson
Newsome Surgery

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

Surname: ……………………………………… Forename(s): ……………..……………… Date of Birth: …………

Marital status: …..………………………… Previous Surname: ……………………………………………………..

Address: ……………………..…………………………………………………………………………………………

………………………………………………………………………………………………… Postcode: ..……………..……….

Home tel: ……………………………..………………………..…… Mobile: ……………..……………………………..…

Email address: ………

Occupation: ……

Weight (approx): ……………………………………..…………….. Height: ……………..……………………………..…

Please tick the box on the right if you consent to being contacted from time to time via SMS text message with news about the practice ☐

Please tick the box on the right if you consent to being contacted from time to time via SMS text message with advice about your health and/or appointment reminders ☐

Date of completion of this form: ……………………

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Ethnic Origin

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

First language:

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Smoking

Do you smoke? *Yes* / *No*

If *Yes*, how many…: Cigarettes per day …….. Ounces of tobacco per day ……..

How old were you when you started smoking? ……

Ex-Smokers

How old were you when you stopped smoking? ……

How much did you smoke per day? …….

Passive Smoking

Are you exposed to passive smoke at work? *Yes* / *No* At home? *Yes* / *No*

Alcohol

For the following questions please circle the answer that best applies:
One drink = 1/2 pint of beer/one glass of wine/one single measure of spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?
Never *Less than monthly* *Monthly* *Weekly* *Daily/Almost Daily*

How often during the last year have you failed to do what was normally expected of you because of drinking?
Never *Less than monthly* *Monthly* *Weekly* *Daily/Almost Daily*

How often during the last year have you been unable to remember what happened the night before because you had been drinking?
Never *Less than monthly* *Monthly* *Weekly* *Daily/Almost Daily*

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?
Yes *No*

Diet

Do you add salt to your food after cooking? *Yes* / *No*

Do you have a varied diet including milk, meat, vegetables and fruit? *Yes* / *No*

Has your cholesterol been checked in the last two years? *Yes* / *No*

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Exercise

Do you take regular exercise? *Yes* / *No*

If yes, what sort of exercise? …….

How many minutes do you typically spend exercising per session? ……

How many times do you exercise per week? ……..

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease (e.g. heart attacks, angina) *Yes* / *No* which family member? …….

Stroke *Yes* / *No* which family member? …….

Cancer *Yes* / *No* which family member? …….

Site of cancer? ……

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

(please attach repeat medication list if available)

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Allergies

Are you allergic to any substances, including medication or foods? *Yes* / *No*

If *Yes*, please give details:

……

……

Past Medical History

Please give details of any hospital treatment as an in-patient:

……

……

Please give details of any treatment for any chronic medical conditions:

……

……

……

Female Patients

Date of most recent cervical smear: ……..

Result of most recent smear: ……

Carers

Does someone look after you? Or do you need / have anyone who looks after you or your daily needs as a Carer? *Yes* / *No*

If *Yes*, would you like them to deal with your health affairs here? *Yes* / *No*
The receptionist can help with these arrangements

Do you look after someone else? *Yes* / *No*
If *Yes*, please ask the receptionist about Carers support

General

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.