**Springfield Road Surgery**

**Adult New Patient Questionnaire**

Thank you for taking the time to complete this questionnaire. The information given is strictly confidential and is important for the nurse or GP who may need to treat you before we have your medical records from your previous GP. You will need one photographic form of identity plus proof of address such as a utility bill, bank statement, solicitor’s letter but not a mobile phone bill.

**Please ensure you complete all sections of this form**

|  |  |
| --- | --- |
| **Date Completed:** | |
| Title: Mr/Mrs/Miss/Other  (Please delete as appropriate) | Surname: |
| Date of Birth: | First Names: |
| Home Telephone No: | Previous Surname: |
| Mobile Phone No: | Email Address (please write clearly) |
| Marital Status: |  |
| Have you ever been registered at Springfield Road Surgery? Yes/No | |
| Occupation: Please state if not working, retired, homemaker or if a student in full or part time education please state the school/college/university you are currently attending: | |

|  |  |
| --- | --- |
| **Next of Kin** | |
| Name: | Relationship: |
| Address:  Post Code: | Home Telephone No: |
| Mobile Telephone No: |

|  |  |
| --- | --- |
| **Are you a carer?** Do you care for a partner, relative or friend? Yes/No (please delete as appropriate) | |
| Name of person you care for: | |
| Relationship to person cared for: | Is person registered at this surgery? |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Ethnicity**  Please choose one category and mark the appropriate box | | | | | | |
| **White** | **Mixed** | **Asian or Asian British** | | | **Black or Black British** | **Chinese or other ethnic group** |
| British | White and Black Caribbean | Indian | | | Caribbean |  |
| Any other white background. Please specify: | White and Black African | Pakistani | | | African | Any other Chinese group. Please specify: |
| White and Asian | Bangladeshi | | | Any other Black background. Please specify: |
| Any other mixed background Please specify: | Any other Asian background Please specify: | | |
| **First Language:** | | | | | | |
| **Non-English Speaking Patients only**  Do you have a family member or friend that can speak English and that you consent to the GP contacting in an emergency **Yes / No**  **If YES,** Please provide:  Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Past Medical/Surgical History:**  Please give details of any relevant history and dates of any hospital admissions, surgery, serious illness, tests or investigations: | | | | | | |
| **1** | | | | | | |
| **2** | | | | | | |
| **3** | | | | | | |
| **4** | | | | | | |
| **5** | | | | | | |
| **6** | | | | | | |
| **7** | | | | | | |
|  | | | | | | |
| **1**  **Allergies**  Please list and give details of any allergies | | | | | | |
| **2**  **Family History**  Please tell us something about you and your family. Has any parent, grandparent or sibling suffered or died from any of the following | | | | | | |
| **Disease** | | | **Family Member** | | | |
| Heart Disease | | |  | | | |
| Stroke | | |  | | | |
| Diabetes (Type 1 or Type 2) | | |  | | | |
| Asthma | | |  | | | |
| Cancer | | |  | | | |
|  | | | | | | |
| I**mmunisations/Height and Weight** | | | | | | |
| Date of last Tetanus if known: | | | | | | |
| Height: | | | | Weight: | | |
|  | | | | | | |
| **Exercise and Activity** | | | | | | |
| How much walking do you do each day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes | | | | | | |
| Do you take any regular exercise (more than one hour per week) or participate in any sport? Eg visit the gym, cycle, job, play tennis, football, netball, etc  **Yes/No** | | | | | | |
| If yes please specify what you do, how many times per week and length of time spent on each activity | | | | | | |
| If you are active in other ways such as gardening, DIY or household chores, please specify | | | | | | |
|  | | | | | | |
| **Smoking** ([please tick appropriate box) | | | | | | |
| Never Smoked | | | |  | | |
| I currently smoke | | | | How many cigarettes per day or oz tobacco per week | | |
| I am an ex-smoker | | | | I gave up in ……….(year) | | |
| If you are currently a smoker but are considering stopping, an information leaflet is available at reception for advice and tips. | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Alcohol**  Please circle the answer that best describes your drinking habits for the following 3 questions | | | | | |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

|  |  |
| --- | --- |
| **Women Only** | |
| Date of last cervical smear |  |
| Date of last mammogram |  |
| Method of contraception (if applicable |  |