

BEECHWOOD MEDICAL PRACTICE NEW PATIENT QUESTIONNAIRE

Welcome to the practice. This form invites you, as a newly registered patient, to have a health check. Please help us by filling in this form, even if you do not accept the health check, as it may take some time for your previous records to reach us.

PERSONAL DETAILS			
Last name		Date of Birth	
		Place of Birth	
First names		Marital Status	
Address		
		
Postcode		Tel No (Home) Including area code	(Mobile)
Email address			
Occupation			
Emergency Contact Name		Emergency Contact Telephone Number	
First Spoken Language		Will you require an interpreter	Yes <input type="checkbox"/> No <input type="checkbox"/>
What do you consider to be your ethnic background (Please tick)			
<u>Asian or Asian British</u>		<u>Black or Black British</u>	
Bangladeshi	<input type="checkbox"/>	African	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Somali	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>
Asian other please state		Black other please state	
<u>Mixed Background</u>		<u>White</u>	
White & Asian	<input type="checkbox"/>	British	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>	Irish	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	White other please state.....	
Other mixed background please state.....			
Preferred language for reading			
I do not wish to complete this section <input type="checkbox"/>			

➤ Do you suffer/have you suffered in the past from any of the following? (Please tick)										
ASTHMA		DIABETES		EPILEPSY						
HIGH BLOOD PRESSURE		CANCER		BRONCHITIS/PNEUMONIA						
HEART PROBLEMS										
MEDICINES										
➤ Please list any medicines, tablets or contraceptive pills you use regularly (including those bought from a chemist)										
Medicine	Dose per day									
FAMILY HISTORY										
➤ Does anyone in your family suffer from (presently/in the past) any of the following? Please tick and state how old they were at the time.										
	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle
Heart Attack/Angina										
Diabetes										
Stroke										
Asthma										
High Blood Pressure										
Cancer (state type)										
Glaucoma										
ALLERGIES										
➤ Are you allergic to any medicine or any other substances? EG pollen, nuts, other foods										
➤ If yes please give details										

VACCINATIONS

➤ What date, approximately, did you last have the following? Please list any other you have had.

TETANUS –
POLIO –

LIFESTYLE

➤ Do you smoke? Yes No If Yes how many per day _____

Please state type (cigarettes, cigars, tobacco) _____

➤ Have you ever smoked Yes No If Yes how many and when did you stop _____

Do you drink alcohol? Yes No If Yes how many units per week _____

1 unit = 1 glass of wine, 1 measure of spirit, half a pint of lager

➤ What is your height? _____

➤ What is your weight? _____

➤ Do you follow a particular diet? (give details)

➤ How often do you exercise for 20 minutes or more at a time? (including brisk walking)

➤ What type of exercise is it? _____

CARER/NEXT OF KIN

➤ Are you a carer? Yes No

➤ Do you have a carer? Yes No If yes please ask at reception for more details.

➤ Name and contact details of next of kin

Name _____ Tel Number _____

Door Code (If appropriate) _____

PLEASE BRING A SAMPLE OF URINE WHEN YOU ATTEND FOR YOUR HEALTH CHECK. If you do not wish to accept the offer of a health check, please return the completed form to reception as soon as possible.

Patient records are held on computer as well as paper. GPs are responsible for the confidentiality of these records. On occasions we share information from the patient records with the Health Authority, Primary Care Trust, hospitals and other NHS/partner organisations in the interests of patient care.

I agree to my medical records being held under the above terms and I certify that the information I have provided is correct to the best of my current knowledge.

Signature:.....**Date:**.....

WOMEN ONLY SECTION

IT IS VERY IMPORTANT THAT YOU COMPLETE THIS SECTION SO THAT WE HAVE AN ACCURATE SMEAR RECORD FOR YOU IMMEDIATELY

- How many times have you been pregnant? _____
- How many deliveries have you had? _____
- Type: (e.g. normal, caesarian): _____ State if premature (how many weeks?) _____
- Any problems e.g. raised blood pressure _____

➤ Date of last cervical smear test _____
 Where was the test taken? (Please tick)

GP	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Abroad	<input type="checkbox"/>
Family Planning Clinic	<input type="checkbox"/>	Private	<input type="checkbox"/>	Other	<input type="checkbox"/>

What was the result? (Please tick)

Normal, routine recall - 3 years	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>
Normal, early recall – 1 year	<input type="checkbox"/>	Borderline Changes, recall – 6 months	<input type="checkbox"/>
Normal, early recall – 6 months	<input type="checkbox"/>	Inadequate, recall – 3 months	<input type="checkbox"/>

- If abnormal are you currently having treatment? Yes No
- Have you had an abnormal smear in the last 10 years? Yes No

- I do not require cervical screening services?
 (ie due to hysterectomy, never sexually active etc.)
- If you have had a total hysterectomy please give the date _____
- Reason _____

Are you currently using contraception Yes <input type="checkbox"/> No <input type="checkbox"/> If so what type? _____	If you are 50 -60, when did you last have a mammogram? _____
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Signature _____ Date: _____