RUABON MEDICAL CENTRE - NEW PATIENT QUESTIONNAIRE

Today's date_____

1. Personal Details:	
Surname	Previous surnames
Forenames	
Date of birth	Place of birth
Address Postcode	Previous address Postcode
Landline telephone	Mobile telephone
e-mail address	NHS number
Next of Kin Name and Relationship to you:	Contact Number for Next of Kin:
Name and address of your previous GP	

2. Ethnic Group:	
White [ ]	British [ ] Irish [ ] Other [ ] (Please specify)
Black [ ]	Caribbean [ ] African [ ] Other [ ] (Please specify)
Asian [ ]	Indian [ ] Pakistani [ ] Chinese [ ] Other [ ] (Please specify)
Mixed [ ]	White + Black Caribbean [ ] White + Black African [ ] White + Asian [ ] Other [ ] (Please specify)

3. Employment:	
Occupation (if you are employed)	
If you are unemployed, is this due to a medical problem? If yes, please give details:	Yes [ ] No [ ]
Have you ever served in the Armed Forces?	Yes [ ] No [ ]
Any other comments?	

4. Medical History:

Have you had any of the following medical problems? (Please tick the boxes as needed)

High blood pressure	[ ]	Asthma	[ ]	Cancer	[ ]
Heart attack or angina	[ ]	Chronic bronchitis (COPD)	[ ]	Thyroid disease	[ ]
Stroke	[ ]	Epilepsy	[ ]	Depression	[ ]
Diabetes	[ ]	Arthritis	[ ]	Stomach/Duodenal ulcer	[ ]

Have you had any other illness, accidents or operations? Yes [ ] No [ ]

If yes, please give details

Are you under the care of a hospital specialist at the present time? Yes [ ] No [ ]

If yes, please give details

Are you taking any medicines or tablets at the moment? Yes [ ] No [ ]

If yes, please give details

Please bring in a list of your repeat medications from your previous surgery
Your new GP will need to approve your medication or contraception before issuing it
You may be asked to come to the surgery to discuss your medication

Height (cms)	Weight (Kgs)

5. Diet and Exercise:

Are you on a special diet? Yes [ ] No [ ]

If yes, please give details

Do you take regular exercise? Yes [ ] No [ ]

If yes, how many half hour sessions per week?

6. Family and Social History

Do you have a family history of heart disease or stroke under the age of 60 years? Yes [ ] No [ ]

If yes, please give details

Do you have a family history of other medical problems? Yes [ ] No [ ]

If yes, please give details

Do you have any social problems which you feel we should know about? Yes [ ] No [ ]
If yes, please give details

7. Allergies and Vaccinations:
Do you have any known allergies? Yes [ ] No [ ]
If yes, please give details
When did you last have a tetanus booster?

8. For Women Only:
Have you ever had problems connected with pregnancy or childbirth? Yes [ ] No [ ]
If yes, please give details
Are you using any form of contraception at the moment? Yes [ ] No [ ]
If yes, please give details
Have you had a cervical smear? Yes [ ] No [ ]
If yes, when was it taken and what was the result?
Have you had a mammogram (breast screening test)? Yes [ ] No [ ]
If yes, when was it taken and what was the result?

9. Alcohol and Tobacco:			
On average, how many days per week do you drink alcohol?			
How much do you drink each time? (Please answer below)			
Pints of beer or cider	Measures of spirits	Glasses of wine or sherry	
Do you smoke? Yes [ ] No [ ] If yes, how much? (Please answer below)			
Cigarettes *Per day*	Roll-your-own *Grams per week*	Pipe *Grams per week*	Cigars *Per day*
Did you used to smoke? Yes [ ] No [ ] If yes, when did you stop? Also, how much did you smoke and for how many years? (Please answer below)			

Cigarettes	Roll-your-own	Pipe	Cigars
Per day *Number of years*	*Grams per week* *Number of years*	*Grams per week* *Number of years*	*Per day* *Number of years*
Would you like advice on how to stop smoking? Yes [ ] No [ ]			

10. Carers:	
Do you care for or help anybody, other than a parent? Yes [ ] No [ ]	
Does anybody care for or help you, other than as a parent? Yes [ ] No [ ]	
The name of the person you care for Address Telephone number	The name of the person who cares for you Address Telephone number

Would you like to receive a New Patient Registration Health Check? Yes [ ] No [ ]

Appt offered 9OW7 [ ] Appt declined 9OW2 [ ] Appt date_____

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE