SOTHALL MEDICAL CENTRE
NEW PATIENT HEALTH QUESTIONNAIRE FOR ADULTS

Now that you have requested to be registered with this practice, we would like you to provide us with some information to help us give you better health care. Please book an appointment at reception for a new patient health check with the healthcare assistant. The information on this form is strictly confidential. Please complete it as fully as you can; thank you.

Proof of identity and current address are required when registering at this Practice. Please bring along with your completed questionnaire at least two of the following: passport / **driving licence / utility bill / Photo ID**

NAME(Mr/Mrs/Miss/Ms)…………………………………………………...DATE OF BIRTH……………………………

ADDRESS ……………………………………………………………………………….…….. POSTCODE …………………

TEL. NO: Home ………………………… Mobile………..…………………..… MARITAL STATUS…………………………

Consent to text messaging? Y/N

OCCUPATION ………………………... PREVIOUS DOCTOR ………………………….…..…

Past illnesses, accidents or operations: (continue overleaf if necessary)
Month & year Hospital Illness/accident/operation

Current medical problems: Anything you are seeing a doctor or hospital for at the moment

Current medication: Please list all tablets and medicines that you are taking regularly overleaf
(Please book in to see one of the doctors for your initial prescription)

Are you allergic to any medicines?

Family History: Has either of your parents or brothers or sisters had any of the following: (please ring)

Cancer Heart attack or angina Stroke Diabetes Blood pressure
High cholesterol Asthma

Smoking, Alcohol and Weight

Have you ever regularly smoked cigarettes? Y/N If you still do, how many?
Have you ever smoked cigars or a pipe? Y/N If you still do, how much?
If you no longer smoke, when did you stop? (year) How much did you smoke?

How much alcohol do you drink, on average, per week ……………………….units
(a unit of alcohol is a half pint of beer, a single measure of spirits or a glass of wine)

How tall are you? ………………. How much do you weigh? ……………………………

Contraception: are you using any form of contraception (please circle)

None Cap Coil Pill Condom Sterilisation Other

Are you an unpaid carer for someone with a chronic disability (mental or physical) Y/N

Ethnicity

I would describe my ethnic origin as follows:

White
- ❑ British
- ❑ Irish
- ❑ Any other White background

Mixed
- ❑ White & Asian
- ❑ White & Black Caribbean
- ❑ White & Black African
- ❑ Any other mixed background

Other Ethnic Group
- ❑ Chinese
- ❑ Any other ethnic group
- ❑ I do not wish to disclose my ethnic origin

Black or Black British
- ❑ African
- ❑ Caribbean
- ❑ Any other Black background

Asian or Asian British
- ❑ Bangladeshi
- ❑ Indian
- ❑ Pakistani
- ❑ Any other Asian background

Is your first language English? Yes/No If no, please state your first language: ❑ I do not wish to disclose my first language

UNTIL WE RECEIVE THIS COMPLETED QUESTIONNAIRE YOU WILL NOT BE REGISTERED WITH THIS PRACTICE

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Office Use Only

Proof of Identity provided: Driving Licence ❑ Passport ❑ Photo ID ❑ Utility Bill with current address ❑

Informed of accountable GP ❑ Staff signature…………………………………….. Date ……………………