NEW PATIENT QUESTIONNAIRE

Meadowpark Street Surgery

We would be grateful if you could complete this questionnaire. It will help us to help you until your records arrive from your previous doctor.

Today's date					
Surname			**First name(s)**		
Date of birth			**Email Address:**		
Address					
Postcode:		**Telephone / Mobile no:**		**Occupation:**	
Ethnicity (please tick)					
White		**Black Caribbean**		**Black African**	
Indian		**Pakistani**		**Bangladeshi**	
Chinese		**Mediterranean**		**Other**	
Name and relationship Of next of kin?			**Contact tel no next of kin** Consent to share this information **with ambulance and emergency services** ☐		
Do you look after someone who is ill, frail, disabled or mentally ill?					
If yes what is relationship to you?					
Name and Address of previous GP					

Past medical problems (include operations) please include date of procedure or medical problem
Current medical problems
Current medications
Allergies

Family history
Is there a history of the following conditions in your immediate family?

Condition	**Relationship**	**Age of onset (approximate)**
Asthma		
Diabetes mellitus		
High blood pressure		
Heart attack		
Stroke		
Others …		
Do you smoke?	Cigarettes / pipe? How much?	Are you ex smoker? How many?

Do you drink alcohol?	Units per week
Weight	Height
How often do you exercise	Are you vegetarian?
Date of last tetanus vaccination	
For women	
Number of pregnancies	Number of children
Date of last cervical smear	
Contraception	

For nurses use	***BP***	***Urinalysis***