NEW PATIENT QUESTIONNAIRE FOR PATIENTS AGED 13 & OVER

WELCOME TO THE VILLAGES MEDICAL CENTRE

PLEASE SPARE A FEW MOMENTS TO COMPLETE BOTH SIDES TO ENSURE WE HAVE UP-TO-DATE INFORMATION ABOUT YOU

First Name:
Last Name:
Title: Mr/Mrs/Miss/Ms/Other
Date of Birth:
Address: Post Code:
Are you a Military veteran/Ex-Army? Yes/No

ETHNICITY *Please tick appropriate box*
□ British
□ Irish
□ Other White
□ White & Black Caribbean
□ White and Black African
□ White and Black Asian
□ Other Mixed Background
□ Indian or British Indian
□ Pakistani or British Pakistani
□ Bangladeshi or British Bangladeshi
□ Other Asian background
□ Caribbean
□ African
□ Other Black background
□ Chinese
□ Other
□ Ethnic category not stated

Telephone No: Mobile No: (Signing the Free Text Reminder sheet gives explicit consent for us to send free text reminders) E-mail address:

Marital Status:

Next-of-kin: Name: Address: Telephone No.

If you have problems with sight, hearing, speech or learning disability, which is your preferred method of communication?
☐ Home/mobile phone ☐ Text ☐ E-mail ☐ Letter (large font available

SMOKING (*please tick one box)*
☐ Never smoked
☐ Ex-Smoker Year stopped smoking ___
☐ Current smoker ________ per day Are you interested in giving up smoking? YES/NO

CARER
Do you look after someone? Does someone look after you?

CURRENT MEDICAL PROBLEMS

Do you suffer from any of the following?

If Yes, please enter year of diagnosis

	YES	NO
Asthma	☐	☐
Cancer	☐	☐
COPD	☐	☐
Heart Disease	☐	☐
Stroke/TIA	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Hypertension	☐	☐
Hypothyroidism	☐	☐
Kidney Disease	☐	☐

CURRENT MEDICATION *Please list*

PAST MEDICAL HISTORY

Please detail any pregnancies, operations, illnesses or allergies:

VACCINATIONS *Please list*

ALCOHOL CONSUMPTION

Please tick one box from each question

1. How often do you have a drink containing alcohol?

a. Never ☐
b. Monthly or less ☐
c. 2 - 4 times a month ☐
d. 2 - 3 times a week ☐
e. 4 or more times a week ☐

2. How many standard alcoholic drinks do you have on a typical day?

a. 1 or 2 ☐
b. 3 or 4 ☐
c. 5 or 6 ☐
d. 7 to 9 ☐
e. 10 or more ☐

3. How often do you have six or more drinks on one occasion?

a. Never ☐
b. Less than monthly ☐
c. Monthly ☐
d. Weekly ☐
e. Daily or almost daily ☐

FAMILY MEDICAL HISTORY

e.g. Asthma, Diabetes, Cancer, Hypertension, Epilepsy, Heart Disease, Stroke, Kidney Disease, Hypothyroidism and age of diagnosis

Father

Mother

Siblings

**** THE NAMED ACCOUNTABLE GP YOU WILL BE REGISTERED WITH WILL BE:- DR AYSHA GHOUZE**

SUMMARY CARE – A Summary Care Record will be made for you, but if you wish to opt out of this then please complete an SCR Opt-out form. You can either download this from the practice website www.thevillagesmc.co.uk or collect a copy from the surgery.

Signature ______________________________ Date ________________