



NEW PATIENT QUESTIONNAIRE

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

Telephone No:
Mobile No:
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?
<input type="checkbox"/> Home/mobile phone
<input type="checkbox"/> Text
<input type="checkbox"/> E-mail
<input type="checkbox"/> Letter (large font available)

ETHNICITY <i>Please tick appropriate box</i>
<input type="checkbox"/> British
<input type="checkbox"/> Irish
<input type="checkbox"/> Other White
<input type="checkbox"/> White & Black Caribbean
<input type="checkbox"/> White and Black African
<input type="checkbox"/> White and Black Asian
<input type="checkbox"/> Other Mixed Background
<input type="checkbox"/> Indian or British Indian
<input type="checkbox"/> Pakistani or British Pakistani
<input type="checkbox"/> Bangladeshi or British Bangladeshi
<input type="checkbox"/> Other Asian background
<input type="checkbox"/> Caribbean
<input type="checkbox"/> African
<input type="checkbox"/> Other Black background
<input type="checkbox"/> Chinese
<input type="checkbox"/> Other
<input type="checkbox"/> Ethnic category not stated

SMOKING (please tick one box)
<input type="checkbox"/> Never smoked
<input type="checkbox"/> Ex-Smoker Year stopped smoking ____
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDICATION	<i>Please list</i>

PAST MEDICAL HISTORY
<i>Please detail any pregnancies, operations, illnesses or allergies:</i>

VACCINATIONS	<i>Please list</i>

ALCOHOL CONSUMPTION
<i>Please tick one box from each question</i>
1. How often do you have a drink containing alcohol?
a. Never <input type="checkbox"/>
b. Monthly or less <input type="checkbox"/>
c. 2 - 4 times a month <input type="checkbox"/>
d. 2 - 3 times a week <input type="checkbox"/>
e. 4 or more times a week <input type="checkbox"/>
2. How many standard alcoholic drinks do you have on a typical day?
a. 1 or 2 <input type="checkbox"/>
b. 3 or 4 <input type="checkbox"/>
c. 5 or 6 <input type="checkbox"/>
d. 7 to 9 <input type="checkbox"/>
e. 10 or more <input type="checkbox"/>
3. How often do you have six or more drinks on one occasion?
a. Never <input type="checkbox"/>
b. Less than monthly <input type="checkbox"/>
c. Monthly <input type="checkbox"/>
d. Weekly <input type="checkbox"/>
e. Daily or almost daily <input type="checkbox"/>

FAMILY MEDICAL HISTORY
<i>e.g. Asthma, Diabetes, Cancer, Hypertension, Epilepsy, Heart Disease, Stroke, Kidney Disease, Hypothyroidism and age of diagnosis</i>
Father
Mother
Siblings

**** THE NAMED ACCOUNTABLE GP YOU WILL BE REGISTERED WITH WILL BE:- DR AARON GUARD**

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.

DATA EXTRACTION – If you wish to opt-out of Data Extraction please complete a Data Extraction form which can be downloaded from the practice website www.thevillagesmc.co.uk or collect a copy from the surgery.

Signature _____ Date _____