**Drs Jasper, Cockell, Jaitly, Hammill, Galayia, Akindele, Patel, Landymore**

**Farley Road Medical Practice**

**NEW PATIENT QUESTIONNAIRE (Over age 14)**

**Please complete in CAPITAL LETTERS These details are essential\***

**\*** Title Mr/Mrs/Miss/Ms/Other………………… **\*** Sex Male  Female

**\*** First Name(s)…………………………………………………………………………………………………………………….

**\*** Surname…………………………………………………………………………………………………………………..………

**\*** Date of Birth …………. \* Date You Completed this Form……………………………………..

**\*** Town and Country of Birth ………………… Do You Speak English? Yes  No

If London, we need the district.

**\*** Contact telephone number(s)

Home……………………………………Business……..……………………………….Mobile……………………………………

E-mail address……………………………………………………..……………………………………………………………….

**\*** Occupation………………………………………………………………………………………………………………………

|  |  |
| --- | --- |
| **Emergency Contact/Relationship** | **Tel** |
| **Address** | |

**\*** Please tick **one** box below that you feel best describes your ethnic origin:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| White British  Any Other White Ethnic Group  Mixed White & Black Caribbean  White & Black African  White & Asian  Any other Mixed background  Asian or Asian British Any other Asian background  Black or Black British Any other Black background  Other Ethnic Group  **First Spoken Language …………………………………………………………………………………..**  **\***  Do You Smoke? Yes  No  If **YES** How many cigarettes / cigars / oz. per day? \* Height & Weight  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Height: |  | Weight: |  | Waist: |  | |

Please be as accurate as possible

**\* Please circle the answer that best applies to you to each of the following questions**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Questions | **0** | **1** | **2** | **3** | **4** | Your Score |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 – 4 times per month | 2 – 3 times per week | 4+ times per week |  |
| How many standardalcoholicdrinks do you have on a typical day when you are drinking?Standard alcoholic unit = half a pint of beer, a 125ml glass of wine, a measure of spirit each count as one unit. | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**DO YOU LOOK AFTER SOMEONE OR DOES SOMEONE LOOK AFTER YOU?**

**IF SO PLEASE FILL IN A CARERS FORM AT RECEPTION**

**Personal Medical History/Disabilities we need to be aware of**

|  |
| --- |
| Please specify any major illness or operations with dates  …………………………………………………………………...............................................................................................  …………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………. |

**Have you suffered from**

|  |  |
| --- | --- |
| Heart Disease/ Heart Attack? Y/N | Strokes? Y/N |
| Blood Pressure? Y/N | Diabetes? Y/N |
| Asthma? Y/N | Eczema/hayfever? Y/N |
| Epilepsy? Y/N | Blindness/Glaucoma? Y/N |
| Cancer? Y/N | Depression/ Mental Health? Y/N |

**Family Medical History**

Has any close relative (parent, brother or sister) suffered from any of the following illnesses:

**Family Member Age Family Member Age**

|  |  |
| --- | --- |
| Heart Disease/ Heart Attack? Y/N | Strokes? Y/N |
| Blood Pressure? Y/N | Diabetes? Y/N |
| Asthma? Y/N | Hyperthyrodisim Y/N |
| Epilepsy? Y/N | Chronic Bronchitis or Emphysema Y/N |
| Cancer? Y/N | Depression/ Mental Health? Y/N |

Any other inherited disease ……………………………………………………………………………..……………………..

Please list any hospital admissions with the reason and approximate date:…………………………………………….....

……………………………………………………………………………………………………………………………………….

**Drugs and Medicines**

Please list ALL prescribed medicines that you take regularly (including the contraceptive pill.)

………………………………………………………………………………………………………………………………………….

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Are you ALLERGIC to any medicines? Yes  No  If yes which ones?

\* **Female Patients Only**

Have you had a Cervical Smear Test within the past 3/5 years Yes  No  Date

Was it Normal? Yes  No 

Where was it done? GP / Hospital / Family Planning Clinic / Abroad / Other

Have you had a hysterectomy? Yes  No 

If **YES**, was it because of cancer? Yes  No 

Have you had a mammogram? Yes  No  If yes, when?

**If you would like a New Patient Check Up with the nursing staff please book at Reception**