SWALLOWFIELD MEDICAL PRACTICE – NEW PATIENT QUESTIONNAIRE

SURNAME ……

FORENAME ……

ADDRESS ……

……

……

DATE OF BIRTH ……

TELEPHONE NO (HOME) ……

TELEPHONE NO (MOBILE) ……

TELEPHONE NO (WORK) ……

EMAIL ADDRESS ……

NEXT OF KIN ……

Tick if you do not want to receive text/email communications ☐

Welcome to our practice. As it may be a while before your past records are sent to us, please complete the details below so that we know as much about you as possible. Please add any extra details you think will be helpful.

Height …… Weight …… Do you smoke? Y☐ / N☐

How many units of alcohol do you drink per week? ……

Have your parents or aunts, uncles, brothers or sisters (before the age of 65) suffered from:

Diabetes	Y☐ / N☐	Please state affected relative ……
A heart attack	Y☐ / N☐	Please state affected relative ……
Angina	Y☐ / N☐	Please state affected relative ……
A stroke	Y☐ / N☐	Please state affected relative ……
Raised blood pressure	Y☐ / N☐	Please state affected relative ……
Breast cancer	Y☐ / N☐	Please state affected relative ……

Are you allergic to any drugs, dressing or food? Y☐ /N☐ – if yes, please state what: ……

Medication:

What regular medication do you take? ……
(include contraceptive pills or injections and all ……
Regular herbal or over the counter remedies) ……

EPS (Electronic Prescribing System) – **For non-dispensing patients only,** What is your nominated chemist? ……
(EPS enables prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff)

Do you have any speech or hearing impediment ? If so, please specify: ……

What is your occupation? …… How many children do you have? ……

Have you ever served in the armed forces? Y☐ / N ☐

Is a member of your immediate family currently a member of the armed forces? Y ☐ / N ☐

If so, please specify: ……

What recreational exercise do you take each week? ……

Are you the carer of a relative/friend/neighbour? Y☐ / N☐
Do you have a carer? Y☐ / N ☐

WOMEN ONLY:

Have you had any miscarriages or any other complications of pregnancy?	Y☐ / N ☐	If so, when? ……
Have you ever had a cervical smear?	Y☐ / N ☐	If so, when? ……
Have you ever had a screening test for breast cancer?	Y☐ / N☐	If so, when? ……