QUEEN SQUARE MEDICAL PRACTICE – NEW PATIENT QUESTIONNAIRE

Surname:_____

Forenames: _____

Date of Birth: ___/___/___ Occupation: _____

Ex-Forces: □ Date left_____

Marital status: Married / Single / Widowed / Divorced / Separated / Partner

Address: _____

Post Code: _____ Home Tel: _____

Work Tel: _____ Mobile: _____

Tick if you do not wish to receive SMS reminders: □

Email address: _____

By providing this information, you will be added to the electronic Newsletter subscription list. EMIS Access is available to make appointments, order prescriptions & view your medical record, please go to our website to register or ask at reception.

Tick if you wish to "Opt-out" and withhold your clinical information from: the SCR (Summary Care Record): □

Next of Kin: _____

□ Emergency contact (tick if applicable)

Relationship:_____

Address:_____

Telephone No:_____

ETHNIC ORIGIN

We are obliged to inform the NHS of your ethnic origin. If, however, you do not wish to disclose this information, please tick the last option.

White - British	
White - Irish	
White - Other Background	
Black or Black British - Caribbean	
Black or Black British - African	
Other Black Background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Chinese or Other Ethnic Chinese Background	
Other Asian Background	
Mixed - White & Black Caribbean	
Mixed - White & Black African	
Mixed - White & Asian	
Other Mixed Background	
Other Ethnic Background	
I do not wish to disclose my ethnic origin	

PAST MEDICAL HISTORY

1 _____ Date: ___/___/___

2_____ Date: ___/___/___

3 _____ Date: ___/___/___

4 _____ Date: ___/___/___

5 _____ Date: ___/___/___

Medicines/Tablets/Regular Prescriptions:

(Please arrange appointment with GP to obtain medication)

1 _____
2 _____
3 _____
4 _____
5 _____

ALLERGIES

Are you allergic to any medicines: YES/NO

Which ones? _____

Any other allergies?_____

FAMILY HISTORY

Diseases that can run in the family:
(Has anyone in your family ever had? please state who)

Heart Disease:_____
High Blood Pressure:_____
Stroke:_____
Diabetes:_____
Eye Disease:_____
Asthma:_____
Cancer:_____
Thyroid disease:_____
Epilepsy/fits:_____
Other:_____

DO YOU look after a relative, partner or friend who needs support because of age, physical or learning illness, including mental ill health? **YES / NO**

If yes, give details

_____
_____

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HEIGHT: _____ **WEIGHT:** _____

WAIST CIRCUMFERENCE: _____

Blood Pressure: _____ / _____
If aged 40+ - please take a reading from the blood pressure machine in Waiting Room D

SMOKING

Have you ever smoked in the past? YES/NO

Do you currently smoke? How much? _____

If a past smoker, how much? _____
Date stopped? _____

ALCOHOL

Daily Units_____ Weekly Units_____

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Score _____/12

EXERCISE

How often do you take strenuous exercise?
Daily……Yes/No
2/3 times per week……Yes/No
Once weekly……Yes/No
Less Frequently …….. Yes/No

DIET

Does your diet normally include?
Daily fruit & veg ……Yes/No
Snacks & fast foods ……Yes/No
Regular fries/chips ……Yes/No
Restrictions (specify) _____

Is there anything else you feel we should know about your health? (E.g. currently pregnant)

_____
_____
_____
_____
_____
_____

Thank you for completing this questionnaire. Please sign and date below.

Signature:…… Date:……....

Office Use Only
Reception Staff to Complete:-
Date received…… Staff Initials:…..…..… New patient appointment needed: YES/NO
Admin Staff to Complete:-
Date added:…….. EMIS No:…….....Registered GP…….. Staff Initials:…..……..…
Template updated YES/NO SMS: YES/NO SCR: YES/NO Audit-C Score:……(Letter sent YES/NO)