Northcote Surgery New Patient Questionnaire

EMIS NO.___________

Personal Details

Date: ....

Surname:.. **First Name(s)** ....

Maiden Name: .... **Parent/Guardian Name:** ....
(If applicable) *(If under 16)*

Date of Birth:.. **Marital Status:** ....

Address: .... **Home Telephone NO.:** ....

.... **Work Telephone NO.:** ....

.... **Mobile Telephone NO.:**......................................

Postcode: .... **Email Address:** ....

Country of Origin:... **Ethnic Group:**..

If from abroad/or you have been a resident in another country please enter the date of entering/returning to UK: ....

Next of Kin: .... **Next Of Kin Relationship:**..

Address: .... **Home Telephone NO.:** ....

.... **Work Telephone NO.:** ....

.... **Mobile Telephone NO.:**......................................

Postcode: ....

Text Reminder Service

The surgery is now able to offer a text reminder service for appointments and requests for health updates (this service is currently only available to patiens aged 16 and over). *Terms & Conditions apply. Please see www.northcotesurgery.com*

Please tick the box if you do not wish to receive information regarding appointments & heath updates by SMS ☐

Online Services

The surgery is now able to offer an online facility for you to book appointments* and to request your repeat prescriptions.
If you are interested please speak to a member of staff or see www.northcotesurgery.com for details. *Terms & Conditions apply*
** Not all appointments are available online.*

Medical Information

	NO	YES	
Do You Have a Carer?	☐	☐	(If Yes Please Provide Carers Name and Contact NO.:)...
Are You a Carer?	☐	☐	(If Yes who for i.e. friend/mother etc:)...

Do You Suffer From Any Of The Following Conditions:

	NO	YES	
Allergies Drug	☐	☐	(If Yes From What Drugs:)...
Allergies Food	☐	☐	(If Yes From What Foods:)...
Angina	☐	☐	(If Yes From What Date/Year:) ....
Arthritis	☐	☐	(If Yes From What Date/Year:) ....
Asthma	☐	☐	(If Yes From What Date/Year:) ....
Anxiety/ Depression	☐	☐	(If Yes From What Date/Year:) ....
Bowel Disorder	☐	☐	(If Yes From What Date/Year:) ....
Chronic Bronchitis	☐	☐	(If Yes From What Date/Year:) ....
Diabetes	☐	☐	(If Yes From What Date/Year and **Type 1 or 2**:) ....
Eczema/ Dermatitis	☐	☐	(If Yes From What Date/Year:) ....
Epilepsy	☐	☐	(If Yes From What Date/Year:) ....
Hay Fever	☐	☐	(If Yes From What Date/Year:) ....
Heart Failure	☐	☐	(If Yes From What Date/Year:) ....

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	NO	YES	
High Blood Pressure	☐	☐	(If Yes From What Date/Year:) ....
Mental Health Conditions	☐	☐	(If Yes From What Date/Year And Condition:) ....
Peptic Ulcer Disease	☐	☐	(If Yes From What Date/Year:) ....
Psoriasis	☐	☐	(If Yes From What Date/Year:) ....
Thyroid Disease	☐	☐	(If Yes From What Date/Year:) ....

Please List Any Other Conditions That Are Not Mentioned: ....

....

....

General Information

Smoking Status

	NO	YES	
Current Smoker	☐	☐	(If Yes From What Date/Year And Number Per Day:) ....
EX-Smoker	☐	☐	(If Yes From What Date/Year Stopped:) ....
Never Smoked	☐	☐	

Alcohol Intake

	Wine	Beer	Spirits
Number Of Units Consumed Per Week	☐	☐	☐
	1 Glass of wine = 1unit	*1 Pint = 2 units*	*1 Measure = 1 unit*

Exercise

What type of exercise are you involved with: General☐ Running ☐ Swimming ☐ Aerobic ☐ Cycling☐ Other ☐

Other Than General How Many Times Per Week Do You Do This: 1☐ 2☐ 3☐ 4☐ 5+☐

Please List Any Medication You Are Currently Taking Or Please Enclose A Copy Of Your Last Repeat Slip

Name Of Drug	Dose /Strength	Reason
....	....	....
....	....	....
....	....	....
....	....	....

Family History

Have Any Of Your Blood Relations Suffered From: (*If Yes Please State the Relative And Age If Known*)

Heart Disease:..................... Diabetes..................... High Blood Pressure ....

Breast Cancer: .... Bowel Cancer: .... Stroke: ....

Other Serious Illness: ....

Female Patients Only

Have You Had Any HPV Vaccines? **1st** ☐ .... **2nd** ☐ .... **3rd** ☐ ....

Do You Have Any Children **NO** ☐ **YES** ☐ (If Yes Please State the Number And Ages) ....

Have You Had Any Miscarriages **NO** ☐ **YES** ☐ (If Yes Please State the Number) ....

Have You Had Any Terminations **NO** ☐ **YES** ☐ (If Yes Please State the Number) ....

Have You Had A Hysterectomy **NO** ☐ **YES** ☐ (If Yes Please State the Type and Year) ....

When Was Your Last Smear Test And Result:.....................

Which Method Of Contraception Are You Using At Present: ....