□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

**Blood Transfusion History**

□

□

**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.:**

**Postcode:**

**Mobile Telephone NO**

**Email Address:**

**Ethnic Group:**

**Next of Kin:**

**Next Of Kin Relationship:**

**Address:**

**Home Telephone NO.:**

**Work Telephone NO.:**

**Mobile Telephone NO**

**Postcode:**

**Text Reminder Service**

*(For staff use alert code: Yes 9NdP or No 9NdQ)*

**Medical Information**

**NO**

**YES**

**Do You Have a Carer? Are You a Carer?**

(If Yes Please Provide Carers Name and Contact NO.:)

(If Yes who for i.e. friend/mother etc:)

Do You Suffer From Any Of The Following Conditions:

**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:)

The surgery offers a text reminder service for appointments and requests for health updates.  
**Please tick the box if you consent receiving text information regarding appointments and health updates**

**Please tick the box if you have ever had a blood transfusion prior to 1996**

If yes, the surgery may contact you to arrange a screening blood test.

**Country of Birth:**

**Occupation:**

□

**Northcote Surgery New Patient Questionnaire**

**EMIS NO.**

**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**:

**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:

OtherSerious 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**Have You Had Any Terminations **NO**Have You Had A Hysterectomy **NO**

**YES**

(If Yes Please State the Number)

**YES**

(If Yes Please State the Number)

**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:

**Consent**

In order to meet data protection requirements do you consent to your personal data being shared with the following organisations

**Other NHS departments/organisations, private healthcare service providers eg. pharmacy, private hospitals Yes/No**

*(For Staff use alert code: Yes = 9NdG and EMISNQC018 or No = 9NdH)*

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

□

(If Yes From What Date/Year Stopped:)

(If Yes From What Date/Year And Number Per Day:)

**Never Smoked**

**Ex-Smoker**

**Current Smoker**

**General Information**

□

□

□

□

□

□

□

□

□

□

□

□

□



in order to assist in your healthcare. **Please circle yes or no below:**

|  |  |  |
| --- | --- | --- |
| **Name Of Drug** | **Dose /Strength** | **Reason** |
|  |  |  |
|  |  |  |

**Medication  
Please List Any Medication You Are Currently Taking Or Please Enclose A Copy of Your Prescription**

5+

4

2

3

**Other Than General How Many Times Per Week Do You Do This:** 1

Other

Cycling

Aerobic

Swimming

Running

**What type of exercise are you involved with:** General

**Smoking Status**

**Exercise**

***1 Glass of wine = 1unit***

***1 Measure = 1 unit***

***1 Pint = 2 units***

**Spirits**

**Beer**

**Wine**

**Number Of Units Consumed Per Week:**