

THE FAMILY PRACTICE 'NEW PATIENT' QUESTIONNAIRE

Name: Maiden Name:
Address: Date of Birth:
..... Place of Birth:
..... **If place of birth is London, please state area:**
Postcode:
Preferred GP: Occupation:
Home Tel: Next of Kin:
Mobile/Work Tel: Next of Kin Tel. No:
Marital Status: Ethnic Origin:
First Language Spoken: **Are you a Carer?**
If yes please ask for a form in reception to fill in.

MEDICAL HISTORY (Please tick where applicable with details and dates if possible)

Asthma: Cancer: Diabetes: Epilepsy/Fits:
Heart Attack: Heart Disease: Stroke: High Blood Pressure:
Osteoporosis: Other: If other please give details:
.....
.....
Operations:
Fractures:
Medication being taken:
Herbal Medicine: Allergies:
Hayfever: Cause if known:

LIFESTYLE INFORMATION (Please delete where applicable)

Do you smoke? YES/NO Current Non-Smoker: YES/NO Never Smoked: YES/NO
Amount daily: Date gave up:
Do you drink alcohol? YES/NO If yes, how many units per week (approx):
Do you exercise? YES/NO Details:
Weight: Height: Waist: