Carterknowle and Dore Road Surgery New Patient Questionnaire

Title: | **DoB:**

First names:

Surname:

Address:

Post Code:

If under 18 please list mother and father:

Mother: | **Father:**

Please list all other people living in the household:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Name of previous GP:

Telephone: | **Mobile:**

Ethnicity:

Asian or Asian British

- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Other Asian Background

Black of Black British

- ☐ African
- ☐ Caribbean
- ☐ Other Black Background

Other Ethnic Group

- ☐ Chinese
- ☐ Any Other Ethnic Group

Mixed

- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean

White

- ☐ British
- ☐ Irish
- ☐ Other White Background

- ☐ I do not with to disclose my Ethnic origin

Do you suffer from any allergies: (including medication) if so which ☐ **Yes** ☐ **No**

Please list any current medication:

Have you suffered from:

- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Cancer
- ☐ Eczema
- ☐ Hay fever
- ☐ Blindness
- ☐ Deafness
- ☐ Diabetes
- ☐ Depression
- ☐ Asthma

Do you smoke? ☐ Yes ☐ Ex-smoker ☐ Never smoked

If yes how many cigarettes per day:

How much alcohol do you drink in a week? **units**

(1 unit = 1/2 pint of beer, 1 small glass of wine, 1 single spirit)

Height: **Weight:**

Please list any other serious illnesses/operations/accidents including any registered disabilities:

(Women only)

Have you ever had a cervical smear? ☐ **Yes** ☐ **No**

If yes please state where and when:

Family History: please list any serious illness within the family, in particular heart disease, stokes, high blood pressure, diabetes or any inherited disease:

Are you a carer? ☐ **Yes** ☐ **No**

If yes please give details:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

For patients over 65 or those with a chronic condition (e.g. asthma or diabetes)

When was your last flu vaccination:

Have you had a Pneumococcal vac.? ☐ **Yes** ☐ **No**

Signed:	**Date:**