

Honiton Surgery New Patient Questionnaire (15 years & over)

Please complete and bring this form to your 'new patient check' which will be with the nurse. If you are on any medication (including contraception) you will also need an appointment with your new doctors. This information will be treated confidentially.

Date

Surname:

Forenames:

Date of Birth:

Address:

Postcode:

Telephone No:

Marital Status:
(please circle)

Single

Married

Divorced

Separated

Widowed

Occupation Now:

Previous Occupation:

Are you a carer? **Y / N**

If you would like to be recorded as a carer, please ask for a Carer's leaflet from Reception

Height:

Weight:

Are you allergic to any drugs or medicines?

Name of Medicine

What happened?

What sort of exercise do you take?

Are you on any special diet **Y / N**, If so, details:

Do you have any current medical problems? (please list below)

Past illnesses including operations, hospital admissions and accidents but not minor illnesses (please continue on separate sheet if necessary)

Year

Do you have you any major handicap or disability? (eg blind, deaf, amputation):

SOCIAL PROBLEMS

Have you any major social problems - eg. unsatisfactory housing, marital problems, problems with a disabled relative?

FAMILY HISTORY

Have any close blood relations (ie, mother, father, brothers, sisters) had the following?

Tuberculosis

Diabetes

High Blood Pressure

Stroke

Hayfever/
Asthma/
Eczema

Angina

Cancer

Migraine

Glaucoma

Thyroid Disease

Mental Illness

Epilepsy

Heart Attack

Did they have a heart attack under age 65?

Y / N

Have you had at least 5 Tetanus injections in your life? **Y / N**

If not, date of Last Tetanus injection:

Do you have 'Flu injections? **Y / N**

Medicines on Prescription (please attach computer repeat medication slip from previous surgery if available or continue on separate sheet)

Are you taking any medicines not on Prescription?
(*eg. laxatives, tonics, headache cures*)

SENIOR CITIZENS

Are you receiving Social Services support? (*eg. Meals on Wheels/Home Help*)
Y / N **Details:**

How mobile are you?

Do you have any major concerns?

Name and telephone no. of next of kin:

Does anyone else have a key to your house/flat? **Y / N**

If so, Name and Address:

Tobacco

Cigarettes (amt/day): Pipe (g/wk): Cigars (amt/day):

Roll ups (g/wk): None:

Tick if previously a smoker How many years did you smoke?
When did you stop?

Alcohol—average weekly consumption in units (*1 unit = 1/2 pt beer, 1 pub measure of spirit or 1 glass wine*)

Spirits: Beer: Other - please state
(glasses)

None:

WOMEN ONLY

Pregnancy History Any complications of pregnancy?

Births: **Miscarriages:** How many months into pregnancy?

Year: Year:

Have you received the German Measles (Rubella) immunisation? **Y / N**

Have you had your immunity confirmed by a blood test? **Y / N**

Date and result of last cervical smear:

Date and result of last mammogram (breast screening):

Do you have current contraceptive needs? **Y / N**

Revised DCW June 2001