Dr Mitchell & Partners

NEW PATIENT QUESTIONNAIRE

SURNAME: …………………………………… FORENAME(S) ………………………………………………

ADDRESS: ……………………………………………………………………………………………...

……………………………. POSTCODE: …………………… TEL NO: ………………………………………

DATE OF BIRTH: …………………………… MARITAL STATUS: ……………………………………….

DO YOU LIVE ALONE? Y / N. OCCUPATION: ………………………………………………………

NEXT OF KIN – Name and Telephone No ………………………………………………………………

ARE YOU THE MAIN CARER OF SOMEONE? Y / N

IS SOMEONE ELSE YOUR MAIN CARER? Y / N

PREVIOUS DOCTOR WITH ADDRESS: ………………………………………………………………

………...

IMPORTANT PAST AND PREVIOUS ILLNESS: (including hospital admissions and operations with approximate dates)

	Yes	*No*		*Yes*	*No*
Heart Disease	☐	☐	Mental Health Problems	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma/Respiratory Disease	☐	☐	Cancer	☐	☐
Other	☐	☐		*Yes*	*No*
FEMALES – Have you had Rubella (German Measles) or been immunised				☐	☐

If yes please give details: ………………………………………………………………………………

………...

OBSTETRIC & GYNAECOLOGY HISTORY (Women) - Please give details of pregnancies, including miscarriages, with approximate dates:

………...

………...

FAMILY HISTORY - Please give details of any illnesses which run in your family:

	Yes	*No*		*Yes*	*No*
Heart Disease	☐	☐	Mental Health Problems	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma/Respiratory Disease	☐	☐	Cancer	☐	☐
Other	☐	☐			

If yes – please give family relationship (i.e. mother), their age and condition: ……..……………………………

……......

…………………………………………………………………………………...……………………………

PTO

REGULAR MEDICATION – Please list names of all tablets, medicines, creams etc. with dosage or times used:
………...

………...

………...

………...

ALLERGIES: MEDICATION: ………………………………………………………………………………..

OTHER (e.g. sticking plaster) ……………………………………………………………………

DO YOU SMOKE? If YES, please estimate quantity per day ☐ If previously smoked please tick here ☐

IF YOU HAVE NEVER SMOKED please tick here ☐ *(read code .1371)*

DO YOU DRINK ALCOHOL? If YES please estimate quantity in units per week ……………………………..
(*1 unit = ½ pint beer/lager / 1 small glass wine / 1 shot spirit)*

DOYOU TAKE REGULAR EXERCISE? Y / N

If yes, how many times a week? …………………………………………………………………………..

What type of exercise? ……..…………………………………………………………………………......

DATE OF MOST RECENT CERVICAL SMEAR (Women) ……………………………………………………

WHAT IS YOUR HEIGHT? …………………….. Metres or …………………………………….. feet/inches

WHAT IS YOUR WEIGHT? …………………… Kilograms or ……………………………... stone/pounds

WHAT IS YOUR ETHINIC ORIGIN?

☐	British or mixed British	(.9i0)	☐	Bangladeshi or British Bangladeshi	(.9i9)
☐	Irish	(.9i1)	☐	Other Asian background	(.9iA)
☐	Other White background	(.9i2)	☐	Caribbean	(.9iB)
☐	White & Black Caribbean	(.9i3)	☐	African	(.9iC)
☐	White & Black African	(.9i4)	☐	Other Black background	(.9iD)
☐	White and Asian	(.9i5)	☐	Chinese	(.9iE)
☐	Other Mixed background	(.9i6)	☐	Other	(.9iF)
☐	Indian or British Indian	(.9i7)	☐	Ethnic category not stated	(.9iG)
☐	Pakistani or British Pakistani	(.9i8)			

You are invited to have a new patient check with our Practice Nurse. Please provide a fresh urine specimen when you attend.

Please Sign …………………………………………..……….. Date …………………………………..

Once completed please hand this form to Reception who can make an appointment for your new patient check.

Thank you for completing this questionnaire