MARCHAM ROAD HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE

Please complete the following questionnaire in as much detail as possible as it will help your Doctor to treat you and your family until your detailed records arrive from your previous Doctor.

YOU WILL NEED TO PROVIDE IDENTIFICATION TO CONFIRM YOUR NAME AND ADDRESS.

THIS SHOULD BE YOUR PASSPORT, BIRTH CERTIFICATE AND/OR MARRIAGE CERTIFICATE AND A UTILITY BILL STATING YOUR NAME AND THE ADDRESS AT WHICH YOU ARE REGISTERING.
(If you are unsure about what documents will be acceptable, please speak to our Receptionists or telephone the Admin Department)

Please delete or leave blank as appropriate, try to answer every question.

Please complete for patients over the age of 13.

Thank you for your time in completing this questionnaire.

The practice has a Patient Participation Group who work with us to represent patient views and opinion. If you would be interested in joining, please contact the Chairman, Mr Robert Lassam at mrhc.ppg@nhs.net

New Patient Details

Title: (Mr, Mrs, Dr, etc). _____ **Surname:** _____

Forename(s): _____ **Sex: Male** ☐ **Female** ☐

D.o.B:. _____ **NHS No:** (as on Medical Card) _____

Address: _____ **Tel. No's:** Home _____

_____ Work _____

_____ Mobile _____

E-mail address: _____

Occupation: _____

Next of Kin: Name: _____ **Relationship:** _____

Telephone No: _____

(This information may be shared with other health care professionals from time to time. If you do not wish this to happen please inform us).

Ethnicity: We are obliged to collect ethnicity information and would therefore be grateful if you would tick the appropriate box shown below.

White British	☐	White Irish	☐	White Other	☐
Black African	☐	Black Caribbean	☐	Indian	☐
Bangladeshi	☐	Pakistani	☐	Chinese	☐
Mixed Race	☐	Other	☐		

Medical Details

Previous Doctor (please include name and address)

1. Please list any serious illnesses, accidents, operations etc. including any pregnancies

Are you currently being treated by a hospital specialist? If yes please give details

Do you currently, or have you ever suffered from any of the following? Please tick those conditions that apply giving any details you can

Asthma	☐	Blindness/Glaucoma	☐	Bronchitis	☐	Cancer	☐
Depression	☐	Eczema	☐	Stroke	☐	Diabetes	☐
Epilepsy	☐	Hayfever	☐	Heart Attack	☐	High Blood Pressure	☐

2. Are you currently taking any drugs (whether prescribed by your doctor or not)

Name of Medicine /Tablets	Dose/Strength	How many times per day
1.		
2.		
3.		
4.		

Please attach a current repeat prescription form from your old GP to this questionnaire if you have one.

Do you have any allergies to medication?

3. Have you been immunised against the following? Please give dates.

Diphtheria	……
Pertussis (Whooping Cough)	……
Polio	……
MMR	……
Polio Booster	……
Measles	……
Rubella	……
Tetanus	……
Tetanus Booster	……
Hepatitis B	……
BCG	……
Other: (please list)……	……
. ……	……
……	……

4. Do you have a major handicap or disability? If yes please give details.

5. Are you cared for? – if you are please give details of your carer. We will contact them to see if they are happy for their details to be included in your records.

6. Are you are carer? Please give details of the person you care for if they are registered as a patient at the surgery.

7. Have you ever served in the Armed Forces? We like to record if you are a Veteran on your medical records as it is important for us to understand more about you and your life experiences.

Yes ☐ No ☐

8. Do you have any issues that may affect your health e.g. employment, housing, marital, disabled family member, dependent relative etc. If yes please give details.

9. Do you have any family history of the following problems:-

Heart Disease	**Cancer**
Stroke	**High blood pressure**
Asthma	**Diabetes**

If yes, please give details of family member and problem.

Lifestyle Details

1. Do you smoke? Yes ☐ No ☐ If yes, since when……..

How many per day? Cigarettes _____ Cigars _____ Pipe Tobacco _____ (oz)

If you have smoked in the past when did you give up? _____

If you currently smoke and wish to give up please make an appointment in our Smoking Cessation Clinic run by our Practice Nurses.

2. Do you drink alcohol? Yes ☐ No ☐

If yes how many units do you have each week?

One unit = 1 single measure of spirits, ½ pint of beer or 125ml glass of wine

Beer/Lager/Cider _____ Wine _____ Spirits _____

For the following questions please circle the answer which best applies.

a) MEN How often do you have EIGHT or more drinks on one occasion?
WOMEN How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

b) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

c) How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

d) In the last year has a relative or friend, or a Doctor or other health worker, been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one Occasion

3. What is your current:

Weight _____ st _____ lb **Height** _____ft _____”

_____kilos _____ metres

4. What do you consider to be your current state of health?

For information about local health services visit www.**my-coach**.org.uk

Information may be shared with other health professionals from time to time. If you do not wish this to happen please inform your Doctor.