

KINGS PRACTICE



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NEW PATIENT QUESTIONNAIRE

SURNAME:

FORENAME:

PREVIOUS/MAIDEN NAME:

DATE OF BIRTH:

ADDRESS

OCCUPATION:

TEL NO:

MOBILE NO.

MARITAL STATUS:

NO. of CHILDREN:

NEXT OF KIN: - Name

Relationship

Tel no

1. Have you ever been registered with this Practice?

(Permanent or Temporary)?

YES/NO

If so, when?

2. Are you at present suffering from any illness, receiving any treatment or medicines?

YES/NO

If YES, please give details including drugs and dosages. Please include medicines you take regularly, that are not prescribed by a doctor.

3. Please give details of any operations, serious illnesses, or accidents in the past:-

Ladies, please include details of any pregnancies

Date

Details and Place

_____	_____
_____	_____
_____	_____
_____	_____

4. Are you allergic to any medication?

YES/NO

Please give details:-

5. Have you been immunised against Tetanus/Diphtheria/Polio in the last 10 years?

YES/NO

For Admin
Cess Advice?

6. Are you A smoker Number/day
 Ex smoker Year stopped
 Never smoked

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7. What is your approximate alcohol intake per week?

8. Alcohol Screening Test

For the following question please circle the answer which best applies

1 drink = ½ pint beer or 1 glass of wine or 1 single spirits

- 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
- Never Less than Monthly Weekly Daily or
 monthly almost daily

9. **WOMEN ONLY**

Date of last cervical smear?

Have you ever had an abnormal cervical smear?

YES/NO

If so what was the subsequent treatment?

Over 50 yrs:- Date of last Breast Screening

10. Over 50 yrs :- Date of last Bowel Screening

11. Do you have a family history of: HIGH BLOOD PRESSURE
 HEART DISEASE THYROID DISEASE
 DIABETES ASTHMA
 STROKE OTHER

If so please indicate below on the grid:-

	DISEASE	AGE OF ONSET
Father		
Mother		
Brother/sister		
Grand Parents		

12. Are you a Carer? **YES/NO** Do you require the help of a carer? **YES/NO**

A Carer is someone who looks after a family member or friend and is not paid for doing so.

For Clinician to complete:-			
BP		Weight	
Urinalysis		Height	
		BMI	
Cholesterol/ CHD Risk			

New Patient Appointment -Date:	
Did Patient Attend?	YES / NO → YES – Form to Admin to complete Registration → NO – Form to Reception to cancel Registration