



New Patient Questionnaire

Please bring this completed form with you to your nurse appointment, along with a fresh urine sample in the bottle provided.

Appointment on:

Personal Details

Surname		Date of Birth	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>day month year</small>
First names		NHS no.	<small>(if known)</small>
Previous name	<small>(if applicable)</small>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address			
Postcode	D E <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Co-habiting <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Telephone Home	<small>With dialling code</small>		
Telephone Work		Height	ft ins <u>or</u> cms
Telephone Mobile		Weight	st lbs <u>or</u> kilos
Email Address			
Passport No.		Occupation	
Proof of address		Ethnic Origin	
		First Language	
Records to be shared on NHS Spine <small>(Tick box to Opt In or Out as appropriate)</small>		Opt In	
		Opt Out	

Next of Kin (or Carer) Details

Name		Relationship to you	
Address	<input type="checkbox"/> Tick if same address as above	Contact no. and other details	

Lifestyle Information

Do you smoke?	<input type="checkbox"/> Never <input type="checkbox"/> Stopped <small>(date)</small> : <input type="checkbox"/> Yes <small>(amount)</small> :	Do you drink alcohol?	<small>If YES, please give amount below</small> /week
Do you exercise?	<small>If YES, please give details below</small>		
What is your diet?	<input type="checkbox"/> No special diet <input type="checkbox"/> High fibre <input type="checkbox"/> Diabetic	<input type="checkbox"/> Low fat <input type="checkbox"/> Vegan <input type="checkbox"/> Other	<input type="checkbox"/> Weight reducing <input type="checkbox"/> Vegetarian <small>- details</small>

Medical History

Do you suffer with any of the following?	<input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart attack/disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Other - <i>details</i>	<i>Please give details including dates</i>	
Operations	<i>Please give details and dates below</i>	Accidents	<i>Please give details and dates below</i>
Current Drugs	<i>Please include dosages</i>	Important Allergies	<i>Please include details of the reaction</i> <input type="checkbox"/> I need to carry an Adrenaline pen
Are you currently under hospital care?	Hospital name Consultant Nature of problem <i>The doctor may discuss with you the possibility of transferring your care to a local hospital</i>	Vaccinations history	<i>Please tick if been performed and give dates of most recent</i> <input type="checkbox"/> Tetanus <input type="checkbox"/> Polio <input type="checkbox"/> German Measles <i>If patient is a child</i> <input type="checkbox"/> Up to date with all jobs

Family History

Are your parents alive and well?	<input type="checkbox"/> Yes <input type="checkbox"/> No - <i>details below</i>	Are your brothers and sisters alive and well?	<input type="checkbox"/> Yes <input type="checkbox"/> No - <i>details below</i>
Is there anybody in your family with any of the following?	<input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart attack/disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Other - <i>details</i>		

Females Only

Last smear	Date Result	Miscarriages	<i>Please give details and dates below</i>
Children	Number Ages	Terminations	<i>Please give details and dates below</i>
Current method of family planning	<input type="checkbox"/> None <input type="checkbox"/> Injection <input type="checkbox"/> Pill <input type="checkbox"/> Coil <input type="checkbox"/> Condom <input type="checkbox"/> Cap <input type="checkbox"/> Sterilisation <input type="checkbox"/> Partner had vasectomy <input type="checkbox"/> Other - <i>details</i>	OFFICE USE ONLY	