Cassio Surgery

New Patient Questionnaire

PERSONAL DETAILS	
Surname:	**First name(s):**
Previous surname(s):	**Sex:** Male/female **Title:** Mr/Mrs/Miss/Ms/Dr/Other
Date of birth:	**Occupation:**
Home address: **Postcode:**	
Home tel:	**Mobile tel:**
Work tel:	**Email:**
CARERS	
Do you look after or support someone who is ill, frail, disabled or mentally ill? Yes/no	
MOBILITY/DISABILITY	
Do you have any problems which make it difficult for you to move around and/or to communicate? Yes/No If YES please give details as it will enable us to make the best arrangements for your care.	
Next of kin:	**Relationship:**
Telephone number(next of kin) :	

HEALTH INFORMATION	
Height:	**Weight:**
Do you smoke? Yes/no Cigarettes/cigars/pipe/roll-ups	**If yes, how many per day?**
Have you ever smoked? Yes/no	**If you have stopped smoking, give approximate date you stopped:**
We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of our smoking cessation services.	
Do you have any allergies? animals/pollen/nuts/medication/other (please specify)	
Have you ever suffered from a bad reaction to any medication? Yes/no If yes, please give details:	
What medication do you currently take? (include both prescription and over the counter):	
What regular exercise do you take?	
How often do you have a drink that contains alcohol? Never Monthly or less 2-4 times per month 2-3 times per week 4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking? 1 - 2 3 - 4 5 - 6 7 - 8 10+	
How often do you have 6 or more standard drinks on one occasion? Never Less than monthly Monthly Weekly Daily or almost daily	

PERSONAL &FAMILY MEDICAL HISTORY

Please give details of any serious illness, accident or special needs, including dates:

Anxiety/Depression	**Yes/No**
Asthma	**Yes/No**
Cancer	**Yes/No**
Diabetes	**Yes/No**
Epilepsy	**Yes/No**
Heart Disease	**Yes/No**
High Blood Pressure	**Yes/No**
Hypothyroidism	**Yes/No**
Mental Illness	**Yes/No**
Operations	**Yes/No**
Stroke	**Yes/|No**

Have any close relatives (parents, brothers, sisters or children) suffered from any of the following or died before the age of 60? Please specify the disease and their relationship to you.

Heart disease (heart attacks/angina)?

Stroke?

Cancer?

Other?

WOMEN ONLY:

Date and place of last cervical/PAP smear:	**Result of last cervical/PAP smear:**
If not in the UK, do you have written evidence of result: Yes/No	**How many pregnancies have you had?**

FOR ALL PATIENTS

If you have children under the age of 16 – for each child:
please state DOB, full name and at which Doctors Surgery they are registered:

PROOF OF IDENTITY

Type of ID ---------- Checked by ----------

Please print name----------

IF NOT BORN IN THE UK:

Place of birth ----------
Date of entry into UK ----------
Where have you lived for the last six months ----------

Please also complete our ethnic monitoring & first language questionnaires.

If you have any other health concerns, please discuss them with a nurse or GP.
Thank you for taking the time to complete this questionnaire.

You do not have to answer any or all of the questions if you do not wish to. However, your answers will be helpful to your Doctor and to the Practice Nurse in planning your care at the Surgery.