Beaumont Park Medical Practice - New Patient Questionnaire

Please complete in CAPITALS in black pen

Name:

Date of Birth:

Age: Tel No:

Occupation: Mobile Phone No:

Ethnic Background:
(e.g. asian, black african, chinese, white, mixed white/african etc)

First Language:

E-mail address: Have you been registered here before? YES / NO

Do you agree to being contacted by sms and email? Yes/No

Who is your next of kin:

Height: Weight:

Health History

Date	Illnesses, accidents or operations

Have you ever suffered from the following?

Epilepsy Yes/No

Asthma Yes/No

Heart Failure Yes/No

Diabetes Yes/No

Stroke Yes/No

Depression Yes/No

Dementia Yes/No

High blood Pressure Yes/No

COPD Yes/No

Heart Disease Yes/No

Kidney Disease Yes/No

Cancer Yes/No

Underactive Thyroid Yes/No

Current Medicines – Name of drug, dose and frequency.

Known Allergies

IF YOU HAVE YOUR PRESCRIPTION SENT TO A CHEMIST, PLEASE GIVE US THE NAME AND ADDRESS OF THE PHARMACY YOU USE.

Family History & Any other Information

Please record any significant family history of close relatives with medical problems
(eg. Surgery, heart attacks, stroke, diabetes, high blood pressure, asthma, glaucoma, cancer, liver and kidney disease)

Please states which family member with condition

Alcohol

Score: **Questions**	**0**	**1**	**2**	**3**	**4**	**Your Score:**
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	

Scoring: A total of 5+ indicates hazardous or harmful drinking

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Smoking status

Have you ever smoked? YES / NO If Yes would you like help to stop? YES / NO

If yes – Do you smoke now? YES / NO Cigarettes per day: Pipe/cigars:

Women Only

Cervical Smear (most recent test)

Date: Result: If not at GP surgery please specify:

Carers

Are you a carer? YES / NO
(Someone who regularly looks after or supports a person who is ill, disabled, frail or in need of emotional support)

A Summary Care Record (SCR) will be created for you unless you tell us otherwise.

Patient Signature…….. Date……

May 2021

Are you registering a child? YES/NO

If you have answered Yes please answer the following questions.

If your child is under 5 do you have the childs immunisation history?	
Are you a foster carer for this child?	
If you are a foster carer is this child “looked after”	