ALFORD MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

DATE: ☐

Title .....

Name .....

Address .....

.....

.....

Home Telephone No .....

Contact No (if different) .....

Occupation .....

Date of Birth .....

Sex Male ☐ Female ☐

Marital Status

Married ☐
Single ☐
Divorced ☐
Widowed ☐
Separated ☐
Cohabiting ☐

Are you a Carer? ☐ Main Care for Someone else ☐ Who for? .....

Which ethnic group do you belong to? - You are not obliged to complete this section

Please tick as appropriate

White Scottish	☐	Indian	☐	Black Caribbean	☐	Other Ethinc Group	☐
White Irish	☐	Pakistani	☐	Black African	☐		
Other White British	☐	Bangladeshi	☐	Other Black Ethnic	☐	I do not wish to give	
Other White Ethnic	☐	Chinese	☐			this information	☐
Other Ethnic Mixed Origin	☐	Other Asian Ethnic	☐				

Medical History

Previous Serious Illnesses

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.....

.....

.....

Operations and Dates

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.....

.....

.....

Present regular medication (please list name, strength and how often taken)

Name	Strength	How often taken
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Drug Allergies

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ADDITIONAL INFORMATION REQUIRED - PLEASE SEE OVERLEAF

NEW PATIENT QUESTIONNAIRE (cont'd)

Family History

Which of your blood relations have suffered from any of the following?

Heart Disease	☐	.....	Cancer	☐	.....
Diabetes	☐	.....	High Blood Pressure	☐	.....
Asthma	☐	.....	Tuberculosis	☐	.....
Stroke	☐	.....	Other Serious Illness	☐	.....

Immunisations

Which vaccinations have you had and when?

Diptheria	☐	.....	Polio	☐	.....
German Measles	☐	.....	Tetanus	☐	.....
Typhoid	☐	.....	Measles	☐	.....
Cholera	☐	.....	BCG	☐	.....
Yellow Fever	☐	.....			

Smoking Habits

Smoker ☐ Number of cigarettes/cigars per day .....

Ex-Smoker ☐ Date Stopped ..... Number of cigarettes/cigars per day .....

Non -Smoker ☐

Alcohol Intake

Please estimate you alcohol intake per week (1 unit = half pint beer or 1 glass wine or 1 measure spirit

Number of units per week .....

Exercise

How many times per week do you exercise for 20 minutes or more? .....

FOR FEMALE PATIENTS ONLY

Have you had any children? ☐ Give Ages .....

Have you had a miscarriage or termination of pregnancy? ☐

Dates .....

Which method of contraception are you using at present? .....

When was your last smear test? .....

Patient Signature _____ If not patient, please state relationshi _____

DO NOT COMPLETE THIS SECTION

Personal Details recorded ☐ by _____

Medical History recorded ☐ by _____

Lifestyle recorded ☐ by _____