BEECHWOOD SURGERY NEW PATIENT QUESTIONNAIRE

Dear Patient

As you are newly registered with the practice and it will be some time before we receive your medical records, it is important for us to obtain as much information as possible about your medical history. Could you therefore please complete this form in as much detail as possible and hand it to the receptionist. **You will then be invited to make an appointment to see the practice nurse or doctor for a New Patient Registration check – this will only take about ten minutes and we advise you to make this appointment.**

Thank You.

TO BE COMPLETED BY THE PATIENT

Surname: Mr/Mr/Miss	First Names
Address:____________________ ____________________ ____________________ ____________________	Date of Birth:________________ Occupation:________________ Tel. No.________________

Have you ever had any serious illness or operations? **Yes** **No**

If yes please give details including the year of occurrence:________________

____

If you are aged 15-74 years please answer the following questions:

Has your Mother, Father, Brother or Sister ever had any of the following:

A HEART ATTACK	**Yes**	**No**
A STROKE	**Yes**	**No**
ANGINA	**Yes**	**No**

If yes please state whom and at what age this first happened:

____

Do you have any diseases that are passed through the family?
For example:- Diabetes, High Blood Pressure **Yes** **No**

If yes please give details:________________________________

____

____

Are you taking any repeat medication at present? **Yes** **No**

If yes please give details including the **name, strength and dosage** of the drug

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____

____

How tall are you?____________ What do you weigh?____________

Have you ever had a Tetanus Injection? **Yes** **No**
If yes, how long ago?____

Are you allergic to any tablets or medicines? **Yes** **No**
Please give details:____

Do you smoke? **Yes** **No**
If yes, state how many per day:________________________________

Do you drink alcohol? **Yes** **No**
If yes, how much would you drink in one week?

Pints of Beer____Lager or Cider____Glasses of Wine____Measures of Spirit___

Do you take any regular exercise (weekly or more often)? **Yes** **No**
If yes, please state what____

Do you eat sensibly, for example cutting down on fatty foods and eating more fresh fruit and vegetables **(be honest)**? **Yes** **No**

Are you a carer for some one who is a patient of this practice ? **Yes** **No**

If yes please give details & record this on your records

Name Address Contact number

Do you have a carer ? If yes please give details & record this on your records

Name Address Contact number

For women only (aged between 18-65 years)

Have you ever had a cervical smear? **Yes** **No**

If yes, what date was it?____

Was the result normal?____

If you would like any further advice on any aspect of your health, please make an appointment to see one of the practice nurses or doctors. We also run a range of clinics details of which can be found in our practice leaflet or our reception staff will be happy to advise.

Thank you for your help