Washington House Surgery

Confidential

New Patient Questionnaire
Under 16 years of age

Welcome to Washington house Surgery. Please help us by filling in this questionnaire, as it may take some time for your previous medical records to reach us. The information you give will be used to provide you with good medical care.

Personal details:

Master/ Miss (please specify): ……

First Name: …….. Surname: ……..

DOB: …….. NHS No: (**Must be supplied**): ……

Address: ……...
……...
…… Postcode: ……

Main contact Tel No: ……

Do you have any disability?: ……
Do you have any special requirements e.g. Hearing aid/wheelchair access/partially sighted? :
……..

Do you care for a relative or friend?: YES/NO

Do you have a carer?: YES/NO
Carer's Name & Contact Details:

Next of Kin: …….
Contact Tel No:...…….

Do you consent to The Health & Social Care Information Centre extracting coded data from your personal records to support analysis and help to provide better care?

I CONSENT

I DO NOT CONSENT

Consent given on behalf of patient due to age or mental capacity

Consent <u>not</u> given on behalf of patient due to age or mental capacity

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You MUST inform all patients of their accountable GP and code it in the template. In the first instance this will be the registering GP unless otherwise requested. The pt can change their mind at any time and the practice will do their best to accommodate their wishes. This does not provide exclusive access to that GP and other GPs may need to be consulted.

Past Medical History

Please give details of any important illness or operations

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Month: ……. Year: ……. Details: ……
Month: ……. Year: ……. Details: ……

Lifestyle

Are you: a smoker ☐ If yes, how many a day ……..
an ex-smoker ☐ When did you stop smoking ……..
never smoked ☐
Do not wish to answer ☐

Are you on a special diet? Yes/No
Please specify ……

How much exercise do you take? None/1xWeek/2xWeek/more often

Form of exercise e.g. Swimming/Cycling……

Family History

Have any close family members suffered from (please include approx. age at diagnosis or age at death):

Asthma: ……. High Cholesterol: ……
Diabetes: …… Cancer (please specify type): ……
Heart Trouble: …… Stroke: …….
High Blood Pressure: ……

Drugs & Treatment

If you are taking any drugs or treatment, please detail below:

Name of medicine ……. Strength ……. Dose/day ……
Name of medicine ……. Strength ……. Dose/day ……

Please advise which Pharmacy you would prefer to collect your prescriptions from:

Washington House **Boots** **Lark Rise**

Do you have any allergies? **YES/NO** If yes, please detail ……....
……...

Please list any immunisations you know or have records for:

Immunisation Date
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Please list any immunisations you know or have records for:

Immunisation Date
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Please list any immunisations you know or have records for:

Immunisation Date

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Ethnic Group

☐ British
☐ Irish
☐ Any other White background
☐ White & Black Caribbean
☐ White & Black African
☐ White & Asian
☐ Any other mixed background
☐ Indian
☐ Bangladeshi
☐ Any other Asian background
☐ Caribbean
☐ African
☐ Any other Black background
☐ Chinese
☐ Any other ethnic group
☐ Pakistani

☐ Do not wish to answer

First Language Spoken

☐ English
☐ Cantonese
☐ Hindi
☐ Polish
☐ Kurdish
☐ Afrikanns
☐ Urdu
☐ German
☐ Spanish
☐ Bangali
☐ Gujerati
☐ Mandarin
☐ Punjabi
☐ Turkish
☐ Pashtu
☐ French
☐ Czech
☐ OTHER, please specify: ……..
