RED PRACTICE, WHITEFRIARS SURGERY
New Patient Questionnaire

Please complete this form as fully as possible. The information will be of importance to provide you with good medical care until we receive your medical records.

Section 1 to be completed by ALL New Patients

Name			**DOB**		
Occupation			**Nationality**		
Ethnic Group Please select from options	British	White Mixed	African	Bulgarian	Indian
or state other:	Scottish	White Mixed	Asian	Polish	Pakistani
First Language :	**Translator required**		**Yes ◯**	**No ◯**	
Please give the name, telephone number, address & relationship of your <u>Next of Kin</u>:					

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Section 2 to be completed by ALL PATIENTS OVER 16 YEARS OF AGE

Do you wish to receive SMS text reminders for appointments and recalls? **Yes ◯ No ◯** **Mobile phone number**					
Please tick if you wish to receive emails for appointments and recalls? **Yes ◯ No ◯** **Email address**					
Are you a smoker? Yes ◯ No ◯	**Have you ever smoked? Yes ◯ No ◯**				
How many cigarettes do you smoke a day?					
The date you stopped smoking					
Do you drink alcohol? **Yes ◯ No ◯** **Approximately how much per week?**					

Your Height	
Your Weight	
Your Blood Pressure	
There is a Blood Pressure machine and a scale in Area 5 of the waiting room for your use	

Women only

Have you had a cervical smear test?	**Yes ◯ No ◯ Year**
Have you had breast screening?	**Yes ◯ No ◯ Year**

Please give present state of health and any serious illnesses in the family.

Father
Mother
Brothers
Sisters
Children

When was your last tetanus and/or polio vaccination?

Have you any allergies? If yes, what are they?

REPEAT MEDICATION - The doctor may wish to see you before you order any medication.

Please name any medication which may upset you?

Please make an appointment with the doctor if you have any concerns about your health.

Are you an unpaid carer?	**Yes ◯ No ◯**
Do you have a carer?	**Yes ◯ No ◯**

Please give the **name and address** of the person who cares for you or you care for.

Have you an Advance Directive (Living Will)?	**Yes ◯ No ◯**

If **Yes**, may we have a copy to file in your medical record?

If **No** and you would like to know more about this, ask at reception for information.