THE ELMS MEDICAL PRACTICE NEW PATIENT QUESTIONNAIRE

Welcome to the Elms Medical Centre. Once you have filled in your registration forms you will need to book an appointment with a Practice Nurse for a new patient check. The Nurse will take a brief history from you and complete a simple health check. It would be very helpful if you could bring a urine sample to this appointment.

Name: **Date of Birth:**

Address: **Email Address:**

Tel Num: **Mobile:**

Ethnic Group: White Black Indian Pakistani Chinese **Other:**

NEXT OF KIN

Name: **Tel Num:**

Address: **Relationship:**

CARERS

Are you a Carer or are you cared for by another?	Carer	Cared for by Another	NO

Name & Address of your Carer:

Relationship to your Carer:

PERSONAL MEDICAL HISTORY

Weight:		**Height:**	
Do you suffer from any of the following?			
Heart Disease	YES / NO	Blood Pressure	YES / NO
Diabetes	YES / NO	Cancer	YES / NO
Asthma	YES / NO	Epilepsy	YES / NO
Thyroid Problems	YES / NO		

If you have answered yes to any of the above please make an appointment to see the Practice Nurse for a review.

Have you had any other significant illnesses or operations that you feel we should know about?

SMOKING

Have you quit smoking?	YES / NO
If so what date did you quit?	
Are you a current smoker?	YES / NO
If YES how many do you smoke?	
Cigarettes	Num Per Day
Cigars	Num Per Day
Pipe	Num Per Day
Roll own	Num Per Day

FAMILY HISTORY

Do any of your family suffer from the following?		Please indicate which family member or members:	
Diabetes	YES / NO	High Blood Pressure	YES / NO
Heart Disease	YES / NO	High Cholesterol	YES / NO
Cancer	YES / NO	Stroke	YES / NO
Asthma	YES / NO	Glaucoma	YES / NO

ALCOHOL	**Scoring System**				
Questions	**0**	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical drinking day?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more

How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How many units of alcohol do you drink in a week?					

ALLERGIES	Are you allergic to anything: **YES / NO** If yes what are you allergic to?
MEDICATION **(**Please note if you are on any medication, you will need to see a GP before this can be prescribed)	**Are you on any medication? YES / NO** If you answered yes please list any medication you take including dosage and frequency. (It would be useful to bring a repeat prescription from your previous surgery.

IMMUNISATIONS:	**(Please tick the Immunisations you have received)**
Two Months Old:	**Diphtheria, Tetanus, Pertussis, Polio, and Hib** ☐
Three Months Old:	**Diphtheria, Tetanus, Pertussis, Polio & Hib, Men C, Rotavirus** ☐
Four Months Old:	**Diphtheria, Tetanus, Pertussis, Polio, Hib, Pneumococcal** ☐
Between 12 & 13 Months:	**Hib/Men C, Pneumococcal, MMR** ☐
3 Years & 4 months old and after:	**Diphtheria, Tetanus, Pertussis, Polio, MMR** ☐
	(For children under 5 it would be very helpful to have a printout of immunisations or please bring the red book)
Girls Aged 12 to 14 years old:	**HPV** ☐
Around 14 Years old:	**Tetanus, Diphtheria, Polio, Men C** ☐
2 Years old – 75+	**Influenza** ☐
65 Years Old:	**Pneumococcal** ☐
70 Years Old:	**Shingles** ☐
If you have a Chronic Disease have you had:	**Influenza** ☐
	Pneumococcal ☐

WOMEN ONLY: Have you ever had a cervical smear? **YES / NO**

If YES when and where?

SUMMARY CARE RECORD (SCR)

An SCR is a centrally held record giving a summary of your health records that can be accessed by a health care professional anywhere in the country should you need to access health services. If you do not wish for your information to be shared in this way please ask at reception for a form that allows you to opt-out from sharing your information in this way.

For Office Use Only

Data Input	☐	Medication	☐
Audit C Entry	☐	Nurses	☐