DR H NAY LIN
MATTOCK LANE, EALING,W13 9NZ

NEW PATIENT QUESTIONNAIRE (ADULT)

Please complete as many questions as you can. Your information will help the Practice to provide better care for you. All information is confidential

Surname…….. **Forename……**

Address……

……..

Telephone Number (Home) …….. **Mobile……**

Date of Birth…….. **Marital Status (Single, Married, Divorced, Widow Widower)**

Sex: M/F **Occupation ……**

Name of Previous Doctor (if any)…….

Previous Surgery Address …….

……..

ETHNICITY GROUP

My ethnic group is (*please tick one of the followings)*

a. British b. British Mixed c. Irish d. White & Asian e. Other White

f. Other Asian g. Caribbean h. African i. Indian British j. Pakistani/British

k. Bang/British bang l. Other black m. Chinese o. Other (please state)……

Do you look after someone? Yes/No If Yes, who…….

Does someone look after you? Yes/No If Yes, who ……

Are you a carer? Yes/No If Yes, are you a volunteer or paid carer?.....

If you are a carer, please request carers identification and referral form at the reception desk.

MEDICAL HISTORY

Are you currently receiving medical treatment organized by your previous GP Surgery?

Yes, No If Yes, please give details of your medical treatment…….

…….

Have you ever suffered from:-

Asthma Y/N Hayfever Y/N Blindness/Glaucoma Y/N Eczema Y/N

Diabetes Y/N High Blood Pressure Y/N Stroke(s) Y/N Heart attack(s) Y/N

Angina Y/N Cancer Y/N Thyroid Condition Y/N

FAMILY MEDICAL HISTORY (please tick)

Please indicate any close relative suffered from

High Blood Pressure Blindness/Glaucoma Diabetes Stroke(s) Heart attack(s)

Asthma Angina Cancer Thyroid Condition

Please state (Father/Mother/Sister/Brother/Aunt/Uncle) ……..

……

SMOKING/ DRINKING STATUS

Do you smoke? Y/N If Yes, how many cigarettes per day ……

Do you drink? Y/N If Yes, how many pints per day/week? ……

If wine, how many glasses per day / week?.....

EXERCISES

Do you undertake any regular exercises/sport? Y/N

If Yes, please state what kind of exercises/sport and how many times a week?

……

……..

DRUGS/MEDICINES

Are you regularly taking any drugs/medicines or tablets/injections? Y / N
If Yes, please give details with the name(s) and dosage(s).

……..

……..

……..

……..

Are you allergic to any tablets/injections/medicines? Y/N

If Yes, please state……

……..

Have you had a Tetanus injection during the last 10 years? Y/ N

If so, when?.....

Your Signature…….

Date……..

<u>FOR WOMEN PATIENTS ONLY</u>

Have you had a cervical smear ? Y/ N If Yes, please provide your result and place of test done.

……

Have you ever had a abnormal smear ? Y/ N If Yes, date and place of test done

……..

Do you use contraceptive pills? If so, which one ……

Are you fitted with a coil? Y/ N If so, which type and when was fitted

…….

Have you ever had a hysterectomy? Y/ N If Yes, when?.....

……

Are you on HRT (Hormone Replacement Therapy)? Yes /No If Yes, since when……..

……..

Have you been vaccinated against Rubella (Measles) Y/ N If Yes, when?.....

……

Signature……

Date……