BRUNEL MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE

Date of Registration: _____ Title: _____

First Name: _____ Surname: _____

Date of Birth: _____ Address: _____

_____ Postcode: _____

Nationality: _____ Ethnicity: _____

Tel No Home: _____ Work/Mobile: _____

Email: _____

Occupation: _____

Are you in the area only temporarily: YES or NO

If temporary - for how long? _____

Are you a carer? (see leaflet at desk if unsure) YES or NO

NEXT OF KIN (to be used for emergencies only):

Name: _____ Relationship: _____

Address: _____ Contact No: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following:

	Yes	No	Age Started
Heart Problems			
Stroke			
Asthma/Lung Disease			
High Blood Pressure			
Diabetes			
(if Diabetic, do you use insulin)			
Epilepsy			
Thyroid Problems			

Do you suffer from any other medical conditions? YES or NO

If yes, please give details: _____

_____

form continues overleaf...

Please list any operations/illnesses in the past: _____

Are you taking any medication (including oral contraception) _____

Do you have any allergies (list): _____

Females only - Have you ever had a smear test? YES or NO

If so, when: _____

Are you currently a smoker? YES or NO

If so, how many cigarettes per day? _____

OR grams of tobacco per day? _____

Are you an ex-smoker? YES or NO

What date did you stop smoking? _____

How many units of alcohol do you drink per week? _____

(One unit = half pint beer OR one glass of wine OR 1 pub measure of spirits)

FAMILY MEDICAL HISTORY (only parents, brothers or sisters)

Have any of them suffered from:

	Yes	No	Age Started
Heart Attacks/Angina			
Stroke			
Diabetes			

Other significant family illnesses: _____

We recommend you make an appointment with the Practice Nurse to have a Blood Pressure Check and discuss any health issues of concern, especially if you suffer from any of the diseases mentioned above. Please bring a urine specimen and any regular medication, including inhalers, with you.

PLEASE NOTE: You will need to see the doctor before the practice can provide prescriptions for repeat medication.

Office Use Only:

BP ……../……. Urine Alb ……. Gluc ……. Ht ……. cm Wt ……. Kg