Valley Medical Centre New Patient Questionnaire

It may be some time before we receive your medical records. In the meantime this questionnaire will give the doctors important information about your medical history and will help us to give a better service.

Have you been registered with this practice before? YES/NO

Surname:	
Forenames:	
DOB:	
Address:	
Home Telephone No: **Mobile:**	Do you agree to text message reminders for appointments and results? YES/ NO
Occupation:	
Marital status:	
Place of Birth:	
Ethnic Origin:	
Main Spoken Language:	

ALCOHOL	YES/NO ……units per week	**SMOKE**	YES/NO……cigarettes per day
YEAR OF LAST TETANUS			

***Children only**

HAD ALL IMMUNISATIONS BEFORE STARTING SCHOOL? YES/ NO

HAD TETANUS/ POLIO INJECTION BEFORE LEAVING SCHOOL? YES/ NO

***Woman only**

Have you ever been pregnant? (if yes, please give details)	
Date of last smear test:	
Are you using contraception (if yes what form are you using?)	

Do you have any medical problems at the moment? YES/NO (please give details)

i.e. are you under the care of a hospital specialist or are you being treated for anything?

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Are you registered disabled? YES /NO (if yes please explain)

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Do you have any allergies? YES/NO (please give details)……

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Have you ever had any of the medical problems below?

Arthritis	YES/NO	Asthma	YES/NO
Cancer	YES/NO	Chronic Bronchitis	YES/NO
Depression	YES/NO	Diabetes	YES/NO
Epilepsy	YES/NO	High Blood Pressure	YES/NO
Thyroid Trouble	YES/NO	Ulcer (duodenal/ gastric)	YES/NO
Stroke	YES/NO	Tuberculosis	YES/NO
Heart Attack/ Angina	YES/NO		

Do you have a <u>family history</u> of any of the following?

If yes please state which family member below					
FH: Hypertension	YES/NO		FH: Diabetes	YES/NO	
FH: Heart Disease >60	YES/NO		FH: High Cholesterol	YES/NO	
FH: Heart Disease <60	YES/NO		FH: Asthma	YES/NO	
FH: CVA/ Stroke	YES/NO		FH: Respiratory Disease	YES/NO	
FH: Cancer	YES/NO				

Are you are carer? YES/NO (if yes please give details below)

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Have you had any other illness, accident or operation in the past? YES/ NO (please give details below)

Description	Hospital	Year

Please list any tablets/ medicines you are taking or attach the right hand side of your previous prescription

Name of tablet/ medicine	Dose/ strength	Daily amount

Do you agree to a summary care record? (please see attached sheet)	YES/NO
Would you like to access our online services? (please enquire at reception after new patient medical – photo ID required)	YES/NO
Has proof of ID been presented to reception during registration?	YES/NO
What form of ID has been provided:	
Date of New Patient Medical:	

Patient Signature:……..Date……..

Thank you for taking the time to complete this questionnaire!