Pitcairn Medical Practice
New Patient Questionnaire

Date: ____/_______/____

Areas are mandatory. Failure to complete may delay the time taken to process your registration

***Surname**: ______________________

***Forename**(s): _______________________

*__**Address**__:

____

____

____

____

Post Code: _____________________

***Date of Birth**/CHI:___________/__________

Marital Status: _______________________

Sex: Male / Female *(delete as applicable)*

Ethnic Group: _____________________

Occupation: ___________________________

*__**Telephone Details**__

Home: ______________________________

Work: _______________________________

Mobile: ______________________________

E-Mail: ______________________________

*__**Next of Kin**:__

Name: ______________________________

Address: _____________________________

____

Tel No: ______________________________

Relationship: _________________________

*Do you give your permission for the surgery to leave a phone message for you to make contact with the surgery? **YES / NO**

If you answered yes-which number would you prefer we used?

Home Work Mobile *(delete as applicable)*

General History

Do you, or have you ***ever*** had, any serious illness or operations? **YES / NO** *(delete as applicable)*

If 'Yes' please enter the date for any major diagnosis, and if you are having on-going treatment.

(If More Space Required Please use Pg 5)

Start date	Diagnosis	Treatment	Specialist

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General History Continued

Are you currently taking any medication? **YES / NO** *(delete as applicable)*

If Yes Please Enter Details Below *(If More Space Required Please use Pg 5)*

Drug name	Drug Dose / Strength	Dose Interval (e.g four times a day, one at night	Reason for Medication

Allergies

Have You Any Allergies, or Had An Adverse Reaction To Any Medication? **YES / NO**

If Yes Please Enter Details Below

Date	What Are You Allergic To?	Nature of Adverse Reaction *if known*

Smoking:

Are You A Current Smoker? **YES / NO** If YES How Much Do You Smoke per Day? ____

Have You Ever Smoked? **YES / NO** If YES When Did You Stop ___/_____/___

Are You An Ex Smoker? **YES / NO** If YES How Many Per Day Did You Smoke? ___

How Many Years Did You Smoke? _____

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Alcohol Intake**: ***(for patients aged 16 and over)

Scoring System

Questions	**0**	**1**	**2**	**3**	**4**	**Your Score**
How often do you have 8 (men)/6(women) or more drinks on one occasion in the last year?	Never	Less than Monthly	Monthly	weekly	Daily or Almost Daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	weekly	Daily or Almost Daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	weekly	Daily or Almost Daily	
Has a relative or friend, doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year.	

Alcohol Consumption Screening Declined ☐ ***(please "√" if you don't want to complete)***

Caring** ***(excluding healthy children aged 16 and under)

Do You Look After Someone? **YES / NO** Does Someone Look After You? **YES / NO**

If Yes to Either Please Enter Details Below

Who Do You Look After / Looks After You and What Help Do They / You Need?

____

____

Female Patients Only

Date of Last Smear: ___/_____/___

Have You Had Any Children? **YES /NO** If 'YES' What Ages? ____________________

Have You Had A Miscarriage? **YES /NO** If 'YES' What Date? ____________________

Have You Had A Hysterectomy? **YES /NO** If 'YES' What Date? ____________________

What Method of Contraception Are You Currently Using, If Any? __________________________

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Family History

Do ANY of your Parents / Siblings Suffer From Any of the Following?

Condition	Parent / Sibling	Approximate Age They Were Affected
Heart Problems		
Cancer		
Diabetes		
High Blood Pressure		
Asthma		
Stroke		
Tuberculosis		
Other Serious Illness		

Vaccinations

Please Indicate Which Vaccinations You Have Had And When

Diptheria **YES/NO/NK** **Date:**	**Polio** **YES/NO/NK** **Date:**
Tetanus **YES/NO/NK** **Date:**	**German Measles** **YES/NO/NK** **Date:**
Typhoid **YES/NO/NK** **Date:**	**Yellow Fever** **YES/NO/NK** **Date:**
Whooping Cough **YES/NO/NK** **Date:**	**BCG** **YES/NO/NK** **Date:**
MMR **YES/NO/NK** **Date:**	

PLEASE USE THIS SPACE FOR FURTHER INFORMATION