Pitcairn Medical Practice
New Patient Questionnaire

Date: ____/_______/____

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

*__Surname__: ____________________

*__Address__:

____

____

____

Post Code: ___________________

*__Forename__(s): ____________________

*__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 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)*

Are you a Forces Veteran? **YES / NO**

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 4)

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 4)

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 - If More Space Required Please use Pg 4

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? _____

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

1 spirit measure = 1 unit
1 pint = 2-3 units
1 x bottle of wine = about 10 units

What is your average weekly alcohol intake? ________units per week

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<u>*Caring</u> : ***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/Termination **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? ____________________________

Family History

Do you have any significant family medical history that you think we should be aware of: e.g Cancer or Cardiovascular Disease? *(If More Space Required Please use Pg 4)*

Condition	Relationship to you; e.g parent/sibling	Approximate Age They Were Affected

Vaccinations:

Have you been fully vaccinated as a child? **YES / NO / NOT KNOWN**

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PLEASE USE THIS SPACE FOR FURTHER INFORMATION