# Eaglescliffe Medical Practice

## New Patient Questionnaire

We would be grateful if you could fill in this questionnaire. It is confidential and will help us to provide a better service. **Please return the completed questionnaire to the surgery along with your registration form. Failure to do so will delay your registration with the practice**

Name

Address

Postcode

Date of Birth

Home Telephone

Mobile Telephone

Please specify your first spoken language

Do you have any communication needs?

Occupation

Marital Status

Next of kin

Relationship to you

Address

Telephone No.

**Are you a Carer** for an elderly or disabled person? Yes / No

**Do you have a Carer** Yes / No

**Do you have any children**

Name(s)

Year of birth

**Do the above children reside at your home address? YES/NO**

**MEDICAL HISTORY**

**Do you suffer from?** ( please highlight )

Diabetes / Hypertension / Coronary Heart disease / Stroke / Epilepsy / Asthma / Chronic obstructive airways disease/emphysema

Severe mental health problems / Thyroid disease / Cancer/Kidney disease/Atrial fibrillation/Dementia/or a Learning disability

**Please list all Serious Ilnesses or Operations**

| Approximate date | Details |
|---|---|
| | |

**CURRENT MEDICATION ( incl contraception )**

| Drug Name | Dose | Frequency |
|---|---|---|
| | | |

**Before requesting a repeat prescription we would ask that you see your new GP with a previous computer slip or bring your medicine bottles with you so that we can be sure of names, doses and quantities**

**HEIGHT & WEIGHT**

What is your approx. height?

What is your approx. weight?

**ALLERGIES Please list any drug or other significant allergies**

**FAMILY HISTORY Has anyone in your close family (first degree relatives eg parents, brothers, sisters or children) suffered from:**

| **Illness** *(please tick)* | **Relationship to you** | **Age at diagnosis** |
|---|---|---|
| | | |
| **Breast Cancer** ☐ | | |
| **Bowel Cancer** ☐ | | |
| **Ovarian Cancer** ☐ | | |
| **Diabetes** ☐ | | |
| **Cardiovascular Disease**** ☐ | | |
| ***ie heart disease, angina, heart attack, stroke, transient or mini stroke, peripheral vascular disease.* | | |
| **OTHER (Please specify)** | | |

**IMMUNISATION**

**Have you received a full course of tetanus immunisation (five doses, three given as a baby, one pre school and one as a teenager)**

Yes / No / Don't know

**Have you received a pneumonia vaccine as an adult?** Yes / No / Don't know

**Do you have an annual flu vaccination?** Yes / No / Sometimes

**SMOKING**

**Do you currently smoke?** Yes / No

If yes ? Did you know there are many different treatments and services available in your area to help you stop. Please ask reception for further details or contact 01642 383819

**Have you ever smoked?** Yes / No **If yes, when did you stop?**

**ALCOHOL**

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

1 pint of beer/Lager/Cider = 2 units
1 glass of wine 175ml = 2 units
Bottle of Wine = 9 units
1 alcopop/Can of Lager = 1.5 units
Single measure of spirit = 1 unit

**DIET - Do you follow any of the following diet regimes?**

Low fat diet

Low salt diet

High fibre diet

Weight reducing diet

**EXERCISE - How much exercise do you do?**

Exercise physically impossible

Aerobic exercise 0 x per week

Aerobic exercise 1 x per week

Aerobic exercise 2 x per week

Aerobic exercise 3 x per week

**ETHNICITY**

**It is useful for your doctor to know your ethnic origin, as different diseases are commoner in different races.**

| | | | |
|---|---|---|---|
| White | | Indian | |
| Black Caribbean | | Pakistani | |
| Black African | | Bangladeshi | |
| Black, Other, Non-Mixed Origin | | Other Asian Ethnic Group | |
| Black, Other, Mixed | | Chinese | |
| Other Black Ethnic Group | | Other Ethnic Non-Mixed | |
| | | Other Ethnic Mixed | |

I would rather not answer this question

**For WOMEN**

Do you have a coil, or contraceptive implant? Yes / No

If yes please specify type and date of fitting

Have you had a cervical smear performed in the last 5 years Yes / No / Don't know

Are you a non-UK national aged 16-45 Yes / No If yes have you been immunised against rubella (German Measles) Yes / No / Unsure

**Ex-Service Personel**

**Have you ever been a member of the Armed Forces? Yes/No**

Signed

Date

**YOUR PERSONAL INFORMATION - IT'S YOUR DECISION WHERE IT GOES**

Patients have two choices to make at this time –
1: Your information will be uploaded onto the National Spine/Great North Care Record within the NHS
this will allow hospitals etc to access your medical records.
For further information as to who can view your information and what information is shared please refer to our website.
Please note if you wish to use the electronic prescribing system you cannot opt out.

2. The Government has asked if patients would be happy
to be used for research and statistics. They would take from the practice records
information that would be identified only by NHS number and post code (no names would
be given out) and given to research departments authorised only by the NHS to use.
This research is very important in the search for cures for all major diseases and also for
help in identifying which drugs etc work best for a particular problem.
**To opt of this service please visit Your NHS data matters website**

---

1. I wish to opt out of information been uploaded onto National Spine/Great North Care Record.
Signature …… …. Date of birth ……..
Address ……