ST JOHN'S GROUP PRACTICE

NEW PATIENT REGISTRATION QUESTIONNAIRE

Title _____ Surname _____ First Name _____

Address _____ Date of Birth _____

_____ Home Tel. _____

_____ Mobile/Work _____

Postcode _____ Marital Status _____

Ethnic Origin _____

Gender Male/Female Main Spoken Language _____

Do You Need An Interpreter? Yes/No If So, What Language _____

Next of Kin Details Surname _____ First Name _____

Address _____ Home Tel. _____

_____ Mobile/Work _____

Postcode _____

If under-16 please state which school you attend _____

GENERAL HISTORY

Are you allergic to any medicines or anything else?

_____

HEALTH PROMOTION

Smoking status (please circle)

I've never smoked I stopped smoking in _____ I smoke _____ per day

If you smoke, are you interested in quitting? Yes/No (Please ask at reception for further information)

How often do you have 8 (men) / 6 (women) drinks of alcohol in one day?

Never Less than monthly Monthly Weekly Daily or almost daily

How often during 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 during the last year have you failed to do what was normally expected of you because of your drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, but not in the past year Yes during the last year

Have you now or in the past had problems with substance misuse? Yes/No

BMI

In order to calculate your BMI could you tell us your height and weight?

Weight _____ Height _____

If unsure please ask reception to use the scales

FAMILY HISTORY

Please give details of any of your blood relatives, under 65, who have had any of the following:

Heart Disease/Attack _____

Diabetes _____

Asthma _____

Cancer _____

High Blood Pressure _____

Other Serious Illness _____

_____

VACCINATIONS

Please give dates of which vaccinations you have had (if known):

Diphtheria	_____	Polio	_____	Tetanus	_____
German Measles	_____	Typhoid	_____	Measles	_____
Cholera	_____	BCG	_____	Swine Flu	_____
Yellow Fever	_____	MMR	_____	Whooping Cough	_____
HPV	_____				

For children: a copy of the child's vaccination record would be helpful (e.g. from their Red Book)

FEMALE PATIENTS ONLY

When was your last smear test (if known)? Year _____ **Result** _____

CARERS

Are you a carer? Yes/No Who do you care for? _____

Do you have a carer? Yes/No Who cares for you? _____

If you are interested in joining our Patient Participation Group please ask at the Reception Desk for further details

Thank you for your assistance