

For Office Use Only

Passport/Driving License

Bank statement

Utility Bill

Other please state

Checked by member of staff

Chawton House Surgery
St Thomas Street, Lymington HANTS SO41 9ND

NEW PATIENT QUESTIONNAIRE

The Doctors welcome you to the Practice

As we may not receive your medical records for several months, it would be very helpful if you could tell us a little about yourself in the following confidential questionnaire. Please hand the completed questionnaire in at reception when you register. Thank you for your co-operation.

NAME		Date of Birth	
OCCUPATION			
ETHNIC GROUP <i>Please Circle</i>	WHITE · BLACK AFRICAN · BLACK CARIBBEAN · INDIAN · PAKISTANI · CHINESE · DECLINE TO STATE · OTHER - PLEASE STATE		
ADDRESS			
Telephone numbers	Home	Mobile	Work
Permission to leave answer phone messages	<input type="checkbox"/> Yes <input type="checkbox"/> No	Permission to text you	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address			
Would you like to receive emails of our regular Newsletters and other Surgery information? Please indicate Yes or No in the boxes provided. <input type="checkbox"/> Yes <input type="checkbox"/> No			
PREVIOUS DOCTOR			
SURGERY ADDRESS			

NEXT OF KIN Name, Address and Telephone Number Relationship	
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Please tell us About yourself
Are you a Carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a Carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes please tell us the name & address of your carer:-	
Are you happy for us to contact your carer about you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

CONDITION

YEAR

...About Your Family

Have any close relatives (Father, mother, sister, brother only) ever suffered from any of the following: -Please indicate who in the boxes below:-

Heart Attack	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer

Allergies :- Please list any allergies you have to any drugs/medication:-





Please list any other known allergies:-

...About Your Lifestyle

Please enter your height & weight – if you do not know - please estimate

Height	Weight
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Please enter your blood pressure – please use the blood pressure machine in the conservatory	Systolic (SYS)	Diastolic (DIA)	Pulse (PUL)		
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES do you smoke	CIGARETTES <input type="checkbox"/>	CIGARS <input type="checkbox"/>	PIPE <input type="checkbox"/>		
How many cigarettes/ cigars do you smoke daily?	<1/day	1-9/day	10-19day	20-39/day	40+/day
If you smoke a pipe, how many ounces per week?					
Would you like to be referred to "Quit 4 Life" ?					
Are you an ex smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
How many did you smoke?					
When did you give up?					
Do you drink alcohol?	<input type="checkbox"/> NO <input type="checkbox"/> YES <i>If YES please answer the following questions:-</i> PLEASE CIRCLE YOUR ANSWER IN THE BOXES BELOW				
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Here are some examples of what makes up a standard alcoholic drink:-	 ½ Pint of Regular Beer/Lager/Cider	 Alcopops or Can of Lager/Cider/Beer	 Large Glass of Wine(175ml)	 Single Measure of Spirits
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If you are taking any regular medication or you have any other health issues then please make a routine appointment to see the Doctor