SA1 Medical Centre
NEW PATIENT QUESTIONNAIRE

Name: Date of Birth:

Address: Postcode:

Contact Nos Email Address:

What is your first language? Ethnicity:

Do you need an interpreter? Yes / No Gender:

NEXT OF KIN

Name: Relation:

Address: Postcode:

Contact Nos Email Address:

SMOKING STATUS

Non Smoker: Yes / No

Number per day: 1 - 9 10-19 20-39 40+

Ex-smoker Date ceased:

Please circle or tick above how many you used to smoke

Would you like help to stop smoking: Yes / No

ALCOHOL STATUS (1 UNIT = ½ pint beer, lager, cider, 1 single spirit, 1 small glass of wine)

Teetotaller Yes / No

Light drinker: Less than 1 unit daily/1-6 units weekly

Moderate drinker: 1-2 units daily/7-14 units weekly

Heavy drinker: 3-6 units daily/21-42 units weekly

Very heavy drinker: 7-9 units daily/49-63 units weekly

Stopped drinking: Date ceased:

Please tick above how much you used to drink

EXERCISE STATUS

No Exercise Avoid even trivial exercise Unable to exercise due to health

Light Exercise Moderate exercise Heavy exercise

Competitive Athlete

Weight and Height if known: Weight: Height:

ALLERGIES OR SENSORY PROBLEMS:

Do you have any allergies or sensory problems: Yes / No

If Yes, please give details

Current Illnesses:

Current Medication:

It is the patient's responsibility to provide evidence of any current medication from their previous practice.
It is our Practice Policy for **ALL** new patients to be reviewed.

FAMILY HISTORY: Does your father, mother, brother or sister suffer from any of the following:

Please tick the relevant condition and indicate which relative and age at diagnosis if known.
If the relative died of the condition please give age at death if known. **NB It is your FAMILY history that is required.**

Heart Disease age 60 or under	
Heart disease age over 60	
Diabetes	
Hypertension/High Blood pressure	
Stroke/TA	
Hyperlipidaemia/High Cholesterol	
Cancer	

Type: ---

CARERS:

Do you need/have anyone who looks after you or your daily needs as Carer? Yes / No
If Yes, would you like them to deal with your health affairs here? Yes / No
(A member of Reception staff can help with these arrangements)
Do you care for anyone else? Yes / No
(If Yes, please ask the Reception staff about Carers' support

Miltary Veteran:

Have you ever served in the Armed Forces? Yes / No

In respect of information from the Practice regarding appointments/results etc.:

Consent to receive SMS texting: Yes / No

Consent to receive Emails: Yes / No

Benzodiazepine Policy

Please note that it is the Practice Policy that **we DO NOT prescribe regular benzodiazepine medication or sleeping tablets.** (Examples: Diazepam, Nitrazepam, Temasepam, Zopiclone and Zolpidem)

By signing the following, you are requesting to join the Practice as a patient and are agreeing to comply with the above Benzodiazepine Policy if applicable

Signature: ---

Name: ---

Date: ---