NEW PATIENT QUESTIONNAIRE

The Vauxhall Practice

Personal Details

Preferred Title	Surname	First Names

Address Post Code	Mobile No.

Tel. No (home) Tel. No (Work)	Email Address	Date of Birth

Marital Status	Occupation

We are expected to ask this question and we accept you may wish to decline:
Ethnicity: (please tick)
White ☐ Chinese ☐ Black Caribbean ☐ Pakistani ☐ Black African ☐
Indian ☐ Mediterranean ☐ Bangladeshi ☐
Other (please state)

Preferred language
English/Welsh
(delete as appropriate)

Do you consent to the practice contacting you by **text message** for appointment reminders, invitations to health checks, vaccination reminders, to let you know a prescription is ready for collection, test results or anything else that may be relevant to you care? **YES / NO** (please delete as appropriate)

Your Health

Have you ever suffered from any of the following:	Tick	Date	Details
Asthma			
Diabetes			
Epilepsy			
Thyroid problems			
Stroke			
Mental health problems			
Cancer			
Blindness or Glaucoma			
Heart attack			
Angina			
High blood pressure			
Please give any details of any other serious illnesses			

Have any family members suffered from any of the conditions above? If YES, please give details	
Do you have any disabilities? If YES, please give details and ways you may need assistance	

Current Medication (it may be helpful to provide us with a copy of the right-hand side of your repeat prescriptions)
Please list any current medication below (include contraceptive pill and HRT)

Medication	Strength	Quantity

Vaccination history

Have you had any of the following childhood vaccinations:
Diphtheria ☐ Tetanus ☐ Polio ☐ Measles ☐ Mumps ☐ Rubella ☐ Whooping cough ☐

When was your last tetanus vaccination? ______________

Do you have any **ALLERGIES**? If so, please give details;

Healthy Living

Do you smoke? **YES / NO** If YES; how many _____ cigarettes per day / ______ grams of tobacco per day
Have you ever been a regular smoker? **YES / NO**

Do you drink alcohol? **YES / NO** If YES; how many units per week (*where 1 standard 175ml glass of wine is 2 units/ 1 standard pint of 5% alcohol lager is 3 units*) _____ units per week

How would you describe your diet (tick as many as apply)
Good ☐ Average ☐ Poor ☐ Vegetarian ☐ Vegan ☐ Low fat ☐ Low sugar ☐ Gluten free ☐

How would you describe your daily activity level? Sedentary ☐ Lightly active ☐ Very active ☐

Do you know:
Your Height:
Your Weight:
Your BMI:
Prefer not to say ☐

Please note, we may contact you to offer advice or support based on your submission

Carers

Do you need/have anyone who looks after you or your daily needs as a carer? **YES / NO**
If YES, would you like them to deal with your health affairs? **YES / NO**
If YES please give their details here:

Full name:
Address:

Telephone number: Are they a patient here **YES / NO**

Do **you** care for someone? **YES / NO** Are they a patient here **YES / NO**

Military Veteran

Have you ever served in the armed forces? **YES / NO**

Communication

Do you have any communication needs relating to sensory loss? If so, what are they and how would you like us to communicate with you?

Thank you for taking the time to complete this form, this will help us provide the appropriate care for you, whilst we await your medical notes from your previous practice.

If you would like anyone else to act on your behalf, access your records or collect your prescriptions, please ask a member of the reception team for a consent form.