Please complete this form in **black** ink. *Please remember to sign and date on the last page*

WINCOBANK MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE

Name…… Date of Birth……

Address……

……

……

Telephone number…….. Mobile……..

E-mail address……

Occupation……

Marital Status……

How would you describe your gender? (tick one)

☐ Female
☐ Male
☐ Transgender identity
☐ Non-binary gender
☐ Transsexual

How long have you lived at your current address? ……

How many addresses have you lived at in the last 10 years? ……

Please list addresses and GP'S in the last 10 years.

…… GP ……

…… GP ……

…… GP ……

…… GP ……

…… GP ……

Name address and contact number for next of kin or whom to contact in an emergency.

……

……

Other members of household:

Name	Age	Relationship
……	……	……
……	……	……
……	……	……
……	……	……
……	……	……

Are you a carer? Yes ☐ No ☐

If yes, whom do you care for?

……

……

Which ethnic group do you belong to?

□ White □ Chinese □ Indian □ Bangladeshi □ Pakistani

□ Black-African □ Black Caribbean □ Other (please state) ……

Country of birth…… Preferred language……..

□ I do not wish to give this information

Language spoken (tick one)

☐ English ☐ Albanian ☐ Arabic ☐ Bengali ☐ Cantonese

☐ Czech ☐ Farsi ☐ French ☐ German ☐ Gujarati

☐ Hindi ☐ Kurdish ☐ Latvian ☐ Lithuanian ☐ Mandarin

☐ Pashto ☐ Polish ☐ Portuguese ☐ Punjabi ☐ Russian

☐ Slovak ☐ Somali ☐ Spanish ☐ Tamil ☐ Urdu

Interpreter needed? (circle answer) YES / NO

Medical History

Current Medical Problems

……

……

……

……

Previous Serious Illnesses **Operation and dates**

…… ……

…… ……

…… ……

…… ……

Present Regular Medication

Name of medicine	Strength	How often taken
……	……	……
……	……	……

Present Regular Medication (continued)

Name of medicine	Strength	How often taken
……	……	……
……	……	……
……	……	……
……	……	……

Drug Allergies

……

……

Smoking habits

□ Smoker Number of cigarettes per day……

□ Ex Smoker Date stopped……

Number of cigarettes previously smoked……

□ Non Smoker

Alcohol Intake

Please estimate your alcohol intake per week (1 unit = half pint of beer or 1 glass of wine or 1 measure of spirit).

Number of units……..

Current height……. Current weight…….

Exercise grading

Do you enjoy:

□ Strenuous exercise □ Moderate exercise □ Light exercise

□ Avoid exercise □ Have problems which make exercise difficult

Family History

Is there a history of the following conditions in your immediate family?

	Yes	No	Relationship to you
Asthma	□	□	……
Diabetes	□	□	……
High blood pressure	□	□	……
Heart attack/ heart disease	□	□	……
Stoke	□	□	……

Women Only

Pregnancies (Year) 1 …….. 2 …….. 3 …….. 4 …….. 5 ……..

Any known problems? *If yes, please state*

……

……

<u>*Women Only*</u>

Last cervical smear

When? …….. Where? …….. Result ……..

Are you taking the contraceptive pill? □ Yes □ No

If yes, please state……

Do you have an IUD (coil)? □ Yes □ No

Do you have an implant? □ Yes □ No

Signature ……

Date Form Completed ……