

HIGHCROFT SURGERY NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible. The Information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Surname..... Forename (s).....

Date of Birth:..... Marital status:.....

Address:.....

..... Postcode:.....

Home Tel:..... Mobile:..... Occupation:.....

Weight (approx)..... Height:..... Waist Size (approx).....

SMOKING

Do you smoke? Yes/No

If yes, how many:

Cigarettes per day..... Cigars per day Ounces of tobacco per day.....

How old were you when you started smoking?.....

EX-SMOKERS

How many years did you smoke for?.....

How much did smoke per day?.....

ALCOHOL

How many units of alcohol do you drink per week?.....

(1 unit = half pint of beer, 1 glass of wine or a pub measure of spirits)

EXERCISE

Do you take regular exercise? Yes/No

If yes, what sort of exercise?

How many times per week?

FAMILY HISTORY

Is there any history of the following in your blood-related family (e.g: father, mother, brother, sister)

How old were they on onset?

Heart Disease (heart attacks, angina) Yes/No If yes, which family member?..... Age.....

Stroke? Yes/No If yes, which family member?..... Age.....

Diabetes? Yes/No If yes, which family member?..... Age.....

High Blood Pressure? Yes/No If yes, which family member?..... Age.....

Cancer? Yes/No If yes, which family member?..... Age.....

Site of Cancer?.....

MEDICATION

Please give details of any medication you take (prescribed or otherwise)
If you have a counterfoil from your previous GP, please attach it to this sheet

Name of Drug:..... Name of Drug:.....
Dosage:..... Dosage:.....

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Dosage:..... Dosage:.....

Name of Drug:..... Name of Drug:.....
Dosage:..... Dosage:.....

ALLERGIES

Do you suffer with any allergies?

PAST MEDICAL HISTORY

Do you suffer from any of the following? (please circle)

High Blood Pressure Asthma* Diabetes Heart Disease Thyroid Problems Cancer N/A

*Please give details of year diagnosed and medication/inhalers being used.....
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Please give details of any hospital treatment as an in-patient:

.....
FEMALE PATIENTS

Date of most recent cervical smear:.....

Result of most recent smear:.....

Are you pregnant at the moment?
.....

CARERS

Do you need/have anyone who looks after you or your daily needs as Carer? Yes/No

Do you care for anyone else? Yes/No

CHILDREN UNDER 10 YEARS OF AGE

Could parents please list vaccinations given since birth from their "red book"

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Thank you for completing this questionnaire. A clinician will assess the information provided and will invite you for an initial examination, if felt appropriate within the next few days.

HIGHCROFT SURGERY PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E and then tick ONE box to indicate your background

Name..... Date of Birth.....

A White

	British
	Irish
	Any other white background (please indicate)

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background (please indicate)

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background (please indicate)

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background (please indicate)

E Chinese or other ethnic group

	Chinese
	Any other (please indicate)

PLEASE INDICATE YOUR FIRST LANGUAGE.....