Meadow Dale Group Practice

New patient questionnaire

Our doctors would like to invite you to fill in this questionnaire. Some of this information will go onto our clinical computer systems. This information will help us to provide you with high quality clinical services and will be treated with the utmost confidentiality.

Personal details	
Name:	
Address:	
Postcode:	
Date of birth:	
Telephone number:	
Mobile number:	
Email address:	

Medical details	
Height:	
Weight:	

Past medical history	
Please detail any significant past medical history that you feel we should be informed of:	

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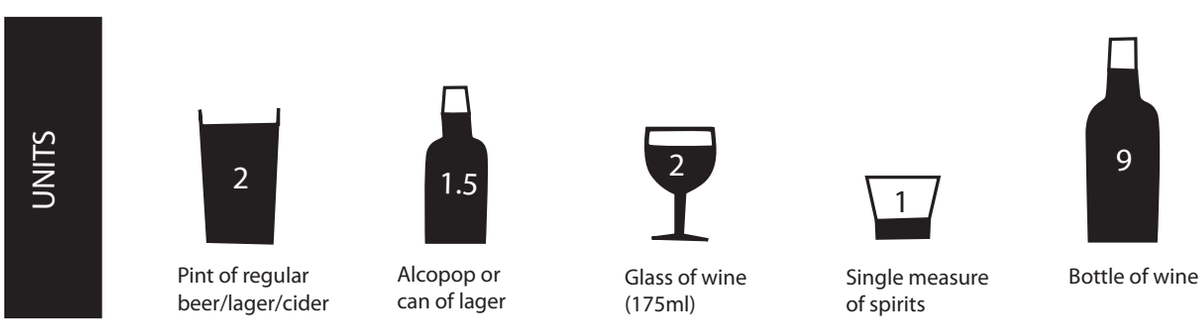
Family history	
Please detail any significant family history that you feel we should be informed of (e.g. asthma, diabetes, epilepsy, stroke, heart attack):	

Lifestyle questions
Please circle from the following: current smoker / ex-smoker / never smoked tobacco
If you are a current / ex smoker, how many cigarettes / ounces per day?
If you are an ex-smoker, what year did you give up smoking?



Based on the key above and the numerical scoring system below please complete the following alcohol screening questions by inputting your score for each question in the appropriate box.

	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	1 - 2 times per week	2 - 3 times per week	4+ times per week	
How many units of alcohol 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 six or more units of alcohol on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

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Disability status	
Do you have a physical disability?	yes / no
Do you have a learning disability?	yes / no
If you answered yes to either of the questions above, please add any further information about your disability that you feel we should be informed of.	

Are you a carer? **yes / no**	Are you housebound? **yes / no**

How would you describe yourself?			
White British		Asian or Asian British - Indian	
White Irish		Asian or Asian British - Pakistani	
Any other white background		Asian or Asian British - Bangladeshi	
Mixed - white and black Caribbean		Asian or Asian British - any other Asian background	
Mixed - white and black African		Black or black British - Caribbean	
Mixed - white and Asian		Black or black British - African	
Mixed - any other mixed background		Black or black British - any other black background	
Prefer not to state ethnicity		Other ethnic groups - Chinese	
		Other ethnic groups - any other ethnic group	

First language	

Religion	

Sexual orientation			
Straight/heterosexual		Gay man	
Bisexual man		Lesbian	
Bisexual woman		Trans	

Medication	
Please list any prescribed medication you are currently taking:	(Please attach a copy of your repeat prescription list if possible).

Over the counter medication	
Please list any over the counter medication that you take on a regular basis:	

Allergies (including drug)	
Please list any allergies that you have:	

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Female patients		
Have you had a hysterectomy?	**yes / no**	Date:
When was your last smear test?	Date:	
Do you know the result?		
When was your last mammogram (only applicable if you are over 50 years of age)?	Date:	
Do you know the result?		

Thank you for your co-operation.