

**Eden Villa Practice
New Patient Questionnaire**



Please complete this questionnaire as fully as possible – your answers will help with your healthcare until your medical records arrive. We will not be able to register patients until this form has been completed.

Title		Address
First name(s)		
Surname		
Tel number home		
Mobile		
Email address		
Occupation		
Marital Status		

ETHNIC ORIGIN - All GPs must now record this for all new patients. _____

If you have migrated to this country could you give your date of arrival? Date _____

Do you require an interpreter? Yes No

If yes, of what language? _____

ALCOHOL INFORMATION (*One unit = half a pint of beer, one glass of wine or one pub measure of spirit*)

QUESTION	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
How often do you have eight or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year	

SMOKING INFORMATION

- I am a non smoker
- I am an ex-smoker
- I am a current smoker

How many per day? _____

Are you interested in further information to help you stop? _____

DIET & EXERCISE

Please describe your diet by ticking one or more boxes:

- Varied (regularly includes milk/meat/fruit/vegetables)
- Vegetarian
- Mainly fast or ready prepared foods
- Low fat
- Diabetic
- High fibre

Please tick appropriate box:

- Very active e.g. strenuous sport & training
- Moderately active e.g. jogging or light sport at least 3 times per week.
- Lightly active e.g. walking, gardening, household tasks
- Inactive

SIGNIFICANT FAMILY HISTORY (relating to your immediate family – parents & siblings)

Heart Disease (Heart attacks, angina) before 65 years	Yes / No	Who	_____
Diabetes	Yes / No	Who	_____
Stroke or TIA before 65 years	Yes / No	Who	_____
Depression	Yes / No	Who	_____
Cancer	Yes / No	Who	_____
			Where _____

CURRENT SIGNIFICANT CONDITIONS (do you have any of the following)

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes – Type 1 (<i>Insulin only</i>) | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes – Type 2 (<i>Meds & Diet</i>) | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Heart Disease | | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Dementia | | |

HEALTH HISTORY

Please list any other serious illnesses, accidents, operations or disabilities with dates if possible. Please include any problems in pregnancy or at delivery.

Date of last tetanus injection _____ Please list any other injections _____

MEDICATION & ALLERGIES

Are you allergic to any medications? Yes / No What _____

Are you allergic to anything else? Yes / No What _____

Please state your current repeat medications _____

WOMEN'S HEALTH

Do you have a coil fitted?	Yes / No	Last check _____
Do you take oral contraception / Depo-provera?	Yes / No	If yes, for how long _____ years
Do you have a Nexplanon?	Yes / No	If yes, for how long _____ years
Have you had a cervical smear test?	Yes / No	If yes, year last taken _____
Are you pregnant?	Yes / No	
Are you planning a pregnancy in the next 6 months?	Yes / No	

CARERS

Are you a Carer for someone? Yes / No Who _____

Is this person registered with the Practice? Yes / No

Are you cared for regularly by anyone? Yes / No Who _____

Would you like to find out more about what support we may be able to offer you or other local organisations? Yes / No

CONSENT:

- IF you want other people to receive results or information about you, you need to complete a consent form. Please tick this box and one will be given to you.