**NEW PATIENT QUESTIONNAIRE**

Welcome to Hatfield Health Centre. Please help us by filling in this questionnaire as it may take some time for your previous medical records to reach us. The information you provide is essential to help us with your future treatment.

We would ask that you use the enclosed practice leaflet to familiarise yourself with details of the Practice.

If you have any queries please do not hesitate to contact Reception. All the information on this form will be treated as strictly confidential.

Thank you for your assistance.

**PERSONAL DETAILS**

**Full Name**: **Date of Birth**:

**Address**:

**Postcode**:

**Home Telephone Number**: ………………………………………………………………………………..

**Work Telephone Number**: ………………………………………………………………………………..

**Mobile Telephone Number**: ………………………………………………………………………………..

**Email address**: ………………………………………………………………………………………………..

**Patient Consent for Text Messaging Appointment Reminders**:

* I consent to the Practice contacting me by text message for appointment reminders and clinics
* I acknowledge that appointment reminders by text are an additional service and these may not take place on all/or on any occasion, and that the responsibility of appointments or cancelling them still rests with me. I can cancel the text message facility at any time
* The Practice does not offer a reply facility to enable patients to respond to the sent text message directly
* The Practice will not transmit any information which would enable an individual patient to be identified.
* I agree to inform the Practice if my mobile number changes or if it is no longer in my possession

**Patient signature**: ………………………………………………….. **Date**: …………………………….

**Name & address of previous doctors’ surgery:**

**Lifestyle:**

**ALCOHOL**

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

**HEIGHT / WEIGHT**

What is your height? ................................................ What is your weight? …………………………

**SMOKING STATUS**

Never smoked □ Current smoker □ if so, how many per day? ………………………….……..

Ex-smoker □ Approximate date stopped smoking ……………………………………………..

Would you like further advice about services available to help you stop smoking? □



**Medical History**

Do you suffer with/ever suffered with any of the following illnesses:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ASTHMA | □ | HIGH CHOLESTEROL | □ | DIABETES | □ |
| BREAST CANCER | □ | HIGH BLOOD PRESSURE | □ | STROKES | □ |
| BOWEL CANCER | □ | HEART ATTACK/ANGIA | □ |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OTHER please state:  Do you have any allergies? |  |  |  |  | ⁭ |
|  |  |  |  |  | ⁭ |
|  | ⁭ |  | ⁭ |  |  |

**FAMILY HISTORY**

Have any of your immediate family i.e. father / mother / sister / brother suffered from:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ASTHMA | □ | HIGH CHOLESTEROL | □ | DIABETES | □ |
| BREAST CANCER | □ | HIGH BLOOD PRESSURE | □ | STROKES | □ |
| BOWEL CANCER | □ | HEART ATTACK/ANGINA | □ |  |  |

If you take any medicines, please bring the list from your previous surgery to the dispensary.

If this is not available, please fill in the table below. An example is filled in for you.

|  |  |  |
| --- | --- | --- |
| Drug Name | Drug Strength | How many and how often |
| *Exampolol* | *250mg* | *One, twice a day* |
|  |  |  |
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**MEDICATIONS**

**If you take any medications you need to provide a copy of your last prescription or bring in your labelled medication box(es).**

**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 here? Yes / No

Please provide carers details:

Name: …………………………………………………………………………………………..

Address: …………………………………………………………………………………………...

Postcode: …………………………………………

Contact telephone number/s:

Home: …………………………………………. Mobile: ………………………………………………..

Work: …………………………………………..

Do you care for anyone else? Yes / No

|  |  |
| --- | --- |
| **ETHNICITY** What is your ethnic group? (please tick) | |
| **WHITE**  □ British  □ Irish  □ Any other white background | **BLACK OR BLACK BRITISH**    □ Caribbean  □ African  □ Any other black background |
| **ASIAN OR ASIAN BRITISH**  □ Indian  □ Pakistani  □ Bangladeshi  □ Any other Asian background | **MIXED**  □ White and Black Caribbean  □ White and Black African  □ White and Asian  □ Any other Mixed background |
| **CHINESE OR OTHER ETHNIC GROUP**  □ Chinese  □ Any other Mixed background | **DO NOT WISH TO STATE**  □ Not stated |
| *The ethnic origin categories are those used in the 2001 Census (Office of Population Censuses and Surveys) and are recommended by the Commission for Racial Equality and the Bar Council* | |