Drs Ryan / McGuinness / McAfee / Donaghey

**NEW PATIENT QUESTIONNAIRE** (6years+)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname | Forename(s)Underline the name by which you are known | TitlePlease circle | Gender | DOB |
|  |  | Mr / Ms / Mrs / Miss / Dr |  |  |
| AddressIncluding postcode | Home Telephone Number | Mobile Number |
|  |  |  |
| Country of Birth | Nationality |
|  |  |
| Occupation (optional) | Email |
|  |  |
| Consent to being contacted by text? | What is your first language? | Do you require an interpreter? |
| Yes / No |  |  |
| Next of Kin | Contact Number | Relationship to you |
|  |  |  |
| Do you have a Carer?If yes, please give contact details | **Are you a Carer?**Please circle | Marital StatusPlease tick as appropriate |
| Yes / No | Yes / No | * Married
* Widowed
* Divorced
* Separated
* Single
 |
| **Are you registered disabled?**If yes, please give details | Do you have a sensory impairment?If yes, please tick as appropriate |
|  | Hearing Impairment* Deaf
* Partially sighted
* Blind
 |

|  |
| --- |
| **Medical Conditions**Please tick as appropriate and give any dates that apply |
| * Asthma
* COPD
* High Blood Pressure
* Diabetes
* Cancer
 | * Epilepsy
* Kidney Disease
* Heart Disease / Heart Failure
* Atrial Fibrillation
* Stroke
 | * Heart Attack
* Mental Health
* Other, please state below…
 |
| **List all current Medications** |
|  |
| Allergies | Nominate a chemist for your prescriptions to go to |
|  |  |
| **Family History**List any known diseases |
|  |
| Do you Smoke?(pipe, cigars, cigarettes, roll-ups, e-cigarettes) | Do you drink alcohol? |
| YesPlease state how many per day.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* No
 | YesPlease state average weekly intake,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No |
| Do you/your children have any involvement with Social Services?If yes, please give details of social worker / social services department. | Has there ever been any involvement with Social Services?If yes, please give details of social worker / social services department. |
|  |  |
| *FEMALE PATIENTS ONLY* |
| Have you had a Hysterectomy?If yes, please give the date | When was your last Cervical Smear? |
|  |  |

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_