Drs Ryan / McGuinness / McAfee / Donaghey

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname | Forename(s) Underline the name by which you are known | Title Please circle | Gender | DOB |
|  |  | Mr / Ms / Mrs / Miss / Dr |  |  |
| Address Including 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 Status Please 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? | |
| Yes Please state how many per day.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * No | | Yes Please 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_