PATFORD
House Partnership

NEW PATIENT QUESTIONNAIRE
Confidential

Welcome to Patford House Partnership

Please help us by filling in this questionnaire as fully and accurately as you can as it may take some time for your previous medical records to reach us.
A specimen of urine is required which should be brought in with your registration form.

PERSONAL DETAILS

Title (Mr/Mrs/Miss/Ms/Dr/Other: ____
First Name: ____
Surname: ____
Date of Birth: ____
Address:
____
____
____

Telephone number(s): Landline: __________________ **Mobile:** ___________________
E-mail address: ____
Marital Status: ____________________ **Height:** ____________ **Weight:** ____________
Which ethnic origin do you belong to? Please tick one:
White ☐ Black or Black British ☐ Asian or Asian British ☐ Mixed ☐ Chinese ☐ Other ☐
First Language: ____
Occupation (please give previous occupation if retired)**:** ___________________________
Do you care for a chronically sick or disabled friend/relative? Yes ☐ No ☐
If so, please give their details & relationship to you (if applicable): ________________________

Do you have a carer? Yes ☐ No ☐
If so, please give their details & relationship to you (if applicable): ________________________

Do you live alone? Yes ☐ No ☐
Next of Kin name, contact details & relationship to you:
____
____

Do you have a disability? Yes ☐ No ☐
Please let us know if there is any way we can help you.

HEALTH

Do any of the following apply to you? Please tick as appropriate:

	Yes, currently	**Yes, in the past**	**No, never**
Heart disease	☐	☐	☐
Stomach/duodenal /peptic ulcer	☐	☐	☐
Diabetes Mellitus	☐	☐	☐
Cancer	☐	☐	☐
Asthma	☐	☐	☐
High blood pressure	☐	☐	☐
Stroke	☐	☐	☐
Mental health problems	☐	☐	☐

Have you had any other significant health problems?

Have you had any operations?

LIFESTYLE

Smoking:

Do you smoke? Yes ☐ No ☐ If yes, how many do you smoke per day? _________________

Are these Cigarettes ☐ Cigars ☐ Roll your own ☐ Pipe ☐ (please tick any that apply)

If no, have you ever smoked? Yes ☐ No ☐ When did you give up? ___________________

Smoking is detrimental to your health. If you would like support to give up, please make an appointment with one of our practice nurses.

Exercise:

Do you undertake regular sport or exercise? Yes ☐ No ☐

If yes, please give details: ____

MEDICATION

Please list below any medication you take regularly:

Medication	Strength	How Often

Are there any medications that upset you? ____

Do you have any allergies? ____

Why Patford House Surgery? (Please tick *all* that apply)

Received a surgery leaflet by post ☐
Picked up surgery leaflet in Calne ☐
Close to home/convenience ☐
Previously registered with the surgery ☐
Recommended by relative/friend ☐
Other (please specify)…………………… ☐

Would you be interested in finding out more about our Patient Participation Group?

Yes ☐ No ☐

Please sign: ______________________ Print: _______________________ Date: ________