

NEW PATIENT QUESTIONNAIRE

Practice use only Date & Pt No entered on D/B
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Welcome to Minster Medical Practice. Please help the Doctors by completing this questionnaire as fully and accurately as possible.

PERSONAL DETAILS

Today's date _____

Full Name:	Date of Birth:
Home Address:	Email:
	Occupation:
	Tel No:
Postcode:	Mobile No:

What is your height?	Feet/ins		or	Cm	
What is your weight?	Stones/lbs		or	Kgs	

Contact via email or text message

On occasion Practice staff may wish to contact you via text or email. To enable our staff to use this method of communication we need your signed consent. **It is the individuals' responsibility to inform the practice should they change their email address or mobile number, If you do not, your message may be sent to the wrong destination.**

I give permission for the practice to contact me as stated

Signature

MEDICATION

Please list any medications you are currently taking.

Ethnic Origin

Please State your first spoken language

Please tick one box that most reflects your background. If you do not wish to state your ethnic origin please tick the 'Ethnic category withheld' box.

British or mixed British	Irish	
Indian or British Indian	Chinese	
Pakistani or British Pakistani	Caribbean	
Bangladeshi or British Bangladeshi	African	
White & Black Caribbean	Other Black background (see note 1 below)	
White & Black African	Other white background (see note 1 below)	
White & Asian	Other Asian Background (see note 1 below)	
Other mixed background (see note 2 below)	Ethnic category withheld	
note 1 Please state your country of birth:		
note 2 Please state your ethnicity:		

LIFESTYLE – For patients aged 16 and over

Do you smoke?	Yes / No	If YES how many per day?		
Have you ever smoked?	Yes / No	If YES, amount per day and when did you quit?	QTY:	DATE:
On average how many units of alcohol do you drink in a week? (1 unit = ½ pint of beer or small glass of wine or single measure spirit)				

Please circle the box most appropriate to you for all three questions.

QUESTION	0	1	2	3	4	Total
How often do you have a drink that contains alcohol?	Never	monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Medical History

List below any history of illnesses, operations or disabilities and the date of occurrence:

Details	Date

Do you have any allergies? If so please list below.

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FAMILY MEDICAL HISTORY

Have any close relatives (mother, father, sister, brother) suffered from any of the following?

Condition	Member of family & age at diagnosis	Condition	Member of family & age at diagnosis
Diabetes		Asthma	
Stroke		Blood Pressure	
Heart attack		Cancer	

Do you care for a member of your family or a friend	YES		NO	
Does a member of your family or a friend care for you		YES		NO

Women Only

Are you on contraceptive pill?	Yes/No	Please state which?	
Are you fitted with a coil?	Yes/No	Please state date fitted?	
Have you had a cervical smear?	Yes/No		
If yes, when was it taken and what was the result?	DATE:		RESULT: