

THE MOATHOUSE SURGERY

NEW PATIENT QUESTIONNAIRE

As it may take some time for your previous records to reach us, could you please complete this questionnaire. This is essential to help us provide you with highest standard of medical care.

Personal Details

Marital Status Married / Single / Cohabiting / Widowed

Surname Mr/Mrs/Miss/Ms

Forenames Date of Birth

Previous Surname

Address

Town County Post Code

Tel No Home Work/Contact

Mobile Email

Details of previous GP

Occupation Are you housebound? Yes / No

Are you a Carer ? Yes / No

If the person you are a carer to is a patient at this practice, it will help us if you let us know who they are.

Details Name

Address

Next of kin Name

Address

Medical History

Are you allergic to any drugs ? Yes / No

If Yes please list

Have you suffered from:	Heart disease	Yes / No	Diabetes Mellitus	Yes / No	Stroke/Tia	Yes / No
	High Blood Pressure	Yes / No	Asthma	Yes / No	COPD	Yes / No
	Chronic Kidney Disease	Yes / No	Depression	Yes / No	Cancer	Yes / No
	Mental illness	Yes / No	Epilepsy	Yes / No		
	Hypothyroidism	Yes / No	Heart Failure	Yes / No		

Female Patients only

Date of your last Smear

Where was this done?

Family History

Have your parents or siblings, suffered from the following:

<p style="text-align: center;">Surgery use only</p> <p>Heart Disease <input type="checkbox"/> #12C</p> <p>Asthma <input type="checkbox"/> #12C2</p> <p>Diabetes Mellitus <input type="checkbox"/> #1252</p> <p>High Blood Pressure <input type="checkbox"/> #12C1</p> <p>Mental illness <input type="checkbox"/> #128</p>	<p style="text-align: center;">Surgery use only</p> <p>Glaucoma <input type="checkbox"/> #12A1</p> <p>Breast Cancer <input type="checkbox"/> #1243</p> <p>Bowel Cancer <input type="checkbox"/> #124F</p> <p>Stroke/ Tia <input type="checkbox"/> #12C4</p>
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NEW PATIENT QUESTIONNAIRE CONTINUED

Lifestyle

Alcohol

Scoring System						
Questions	0	1	2	3	4	Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 – 3 times a week	4 or more times a week	
How many units of alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Please circle

Smoking

Smoker

Ex Smoker

Never Smoked

Exercise

Daily

Weekly

Occasional only

Type of Exercise

Moderate

Vigorous

Gentle

STATEMENT OF ETHNICITY (NOT MANDATORY)

Please state your ethnic origin. This will help us with your healthcare as some conditions are more common in specific communities.

- British
- Irish
- Any other white background
- White and black Caribbean
- White and black African
- White and Asian
- Any other mixed background
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background
- Caribbean
- African
- Any other Black background
- Chinese
- Any other ethnic group
- I do not wish to give these details