New Patient Questionnaire

Glenpark Medical Practice welcomes all people who live in our practice area.

We would be grateful if you would complete this confidential questionnaire which we give to every new patient registering with the practice.

Once the completed form is returned, along with the purple registration form (GMS1), we will be able to proceed with registering you with the practice.

If you have photo ID this allows us to provide you with online access, but this is not required to register with the practice.

We require all patients registering with us to attend a “new patient consultation appointment”. This is a meeting with a Practice Nurse which helps us give you the best care and attention possible.

Thank you.

# Your Details

Surname

First Name(s)

Title

What name would you prefer us to use when we call you?

Date of birth

NHS Number (If known)

Home Address

Home Telephone Number:

Mobile Number:

Email address:

*By giving us contact details, you are giving us permission to use these details to contact you in relation to managing your health.*

*The following questions are optional but help us to understand how we can best help you to access ours and other services.*

What is your gender?

What pronouns would you prefer us to use?

⬜ Him / His ⬜ She / Her
⬜ They / Them ⬜ Other:

What is your marital or civil partnership status?

What is your ethnic group?

What is your main language?

If your main language is not English, do you need an interpreter? ⬜ Yes ⬜ No

Are you the main carer for another person (paid or unpaid)? ⬜ Yes ⬜ No

Have you previously served in the armed forces? ⬜ Yes ⬜ No

Do you have any other additional accessible needs?

 ⬜ Registered Blind or other visual loss

 ⬜ Require large font

⬜ Do not write to me

 ⬜ Send written information by email

 ⬜ As plain text ⬜ As a PDF

⬜ d/Deaf

⬜ Sign Interpreter Needed ⬜ Lip Read ⬜ Do not phone me

⬜ I need a carer or communicator to come with me to appointments:

 ⬜ Name: ⬜ Phone:

 ⬜ Other needs:

*We will endeavour to meet these needs and will discuss them with you at your new patient appointment. Some needs, such as Braille, we are currently unable to provide, though we constantly review how we can better support patients with additional needs.*

# Significant Individuals

*We do not discuss your medical or personal information with any person without your permission. However, we ask next of kin details for use in case of emergency.*

Next of Kin Name:

How is the relationship you have with this person?

Next of Kin Number:

Other than you, who else lives at home (even if they aren’t registered with us):

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age (if child)** | **Relationship** | **School (if child)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Past Medical History

(please list any significant health problems/illnesses and any operations you may have had e.g. asthma, diabetes, back pain, etc)

|  |  |
| --- | --- |
| **Date** | **Illness/operation** |
|  |  |

# Drugs and Medicines

Are you prescribed any medication on a repeat basis ⬜Yes ⬜No

Please list any medication taken, including any medicines or remedies bought over the counter (alternatively you could show us your repeat prescription)

|  |  |
| --- | --- |
| **Name of Medication** | **Dose** |
|  |  |

Are you allergic to any medicines? ⬜ No ⬜ Yes, please state below:

……………………………………………………………………………………

# Family Medical History

(is there a family history of any of the following conditions)

⬜ Heart Disease ⬜ Stroke

⬜ High Blood Pressure ⬜ Asthma

⬜ Diabetes

Other?.............................................................................................................................................

Please give details ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

# Lifestyle

Do you smoke?

⬜ Yes If yes, how many per day?

 ⬜ No

Are you an ex-smoker?

⬜ Yes If yes, when was your last cigarette?

 ⬜ No

How many units of alcohol do you drink in a week?..............................................................................

*1 unit is the equivalent of:*



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 single measure of spirits (25mL) | 1 small glass of wine (100mL) | 1 small glass of sherry | ½ pint of ordinary strength beer or cider | ¼ pint of high strength beer or cider |

Do you take regular exercise? ⬜ Yes ⬜ No

If yes, please state type of exercise you do, and how often you do it: …………………………………………………………………………………

Diet

⬜ Good/Healthy

⬜ Moderate

⬜ Poor/Unhealthy

Do you have a special diet (e.g. vegetarian, vegan, diabetic, gluten-free)

……………………………………………

# About You

Do you have any non-drug allergies (i.e. nuts, pollen, insect bites). If yes, please state ………………………………………………………

Have you ever misused drugs or other chemicals? If yes, please state …………………………………………………

When did you last have your tetanus, polio or other vaccinations? ........................................................

**For women:**

When was your last smear?

Do you use contraception? If yes, please state type used (e.g. pill, coil, injection, implant, condom etc)

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