



ST STEPHENS GATE MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

Thank you for joining our Practice
Please complete the following brief Questionnaire

Surname: _____ First Names: _____

D.O.B.: _____

Are any members of your Family registered with the Practice?

Parents: Spouse: Partner: Children: Other: (Please state relationship)

How did you hear about the Practice? Website: Relative/Friend Internet search
Practice advertisement

Other (Please state)

Reason for Joining the Practice: Moved into Area Convenient location Opening Times
Choice of Appointments Specialist care available e.g. diabetic clinic

Other (Please state)

PERSONAL MEDICAL HISTORY:

Please tick the box if you have suffered from:

- | | |
|--|---------------------------------------|
| High Blood Pressure <input type="checkbox"/> | Heart attack <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Epilepsy/Fits <input type="checkbox"/> | Cancer <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Other : _____ |

Any operations in the past: Yes No If yes please specify _____

Any current illness: Yes No If yes please specify _____

Are you taking any Medication? Yes No

If yes - please list below all current medications, including any hay fever treatment.

Are you allergic to any Medication Yes No

If yes please specify: _____

Continued overleaf

PERSONAL INFORMATION:

Current Weight: _____ Height: _____

Do you smoke: Yes No SMOKING CAN DAMAGE YOUR HEALTH

If yes how many a day Smoking cessation advice is available, make an appointment now.

Do you drink: Yes No

How much weekly intake:

Full Pints

Glasses of Wine

Spirits

Do you exercise regularly Yes No

If yes please give details: _____

Family History (ie Parents Brothers Sisters)

Is there a family history of: Asthma
 Heart Disease
 Cancer
 Diabetes or Stroke

If Yes please specify: _____
 _____**Female Patient Only**

Date of last Cervical Smear: _____ Results: _____

Are you using Contraception: Yes No Which Method: Pill Condom Other

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- Please provide a urine sample for routine testing – Specimen Bottles provided at the Reception.
 - If you wish, our Practice Nurse can offer a full Health Check.
 - Based on the above information, we may wish to invite you for a Personal Health Check with a doctor.

If you have any further questions please feel free to ask on of the Receptionists.

Welcome to St Stephens Gate Medical Practice