

QUESTIONNAIRE FOR NEW PATIENTS

TITLE: Mr/Mrs/Miss/Ms ----- **FULL NAME:** -----

ADDRESS : -----

----- **POST CODE:** -----

TELEPHONE NUMBER: ----- **DATE OF BIRTH:** -----

MARITAL STATUS: Single/Married/Divorced/Separated/Widowed/Co-Habiting

ETHNIC GROUP:

A British/mixed	F White & Asian	K Other Asian	P Other - ethnic
B Irish	G Other mixed	L Caribbean	Q Ethnicity not stated
C Other White	H Indian/British	M African	
D W&B Caribbean	I Pakistani/British	N Other black	
E W&B African	J Bang/Brit Bang	O Chinese	

FIRST LANGUAGE: -----

OCCUPATION: -----

PREVIOUS OCCUPATIONS: -----

DO YOU LOOK AFTER SOMEONE WHO HAS A LONGTERM ILLNESS, IS DISABLED OR FRAIL? Yes / No

IF YES, NAME OF PERSON YOU ARE CARING FOR AND RELATIONSHIP TO THEM

ARE YOU BEING CARED FOR? YES/NO

IF YES, NAME OF YOUR CARER AND RELATIONSHIP IF APPLICABLE

SMOKING AND ALCOHOL:

DOLPHINS PRACTICE ADVISES A NO SMOKING LIFESTYLE. PLEASE CONTACT RECEPTION IF YOU NEED HELP TO STOP SMOKING.

PLEASE COULD ADVISE IF YOU ARE:	CURRENT SMOKER	Y / N
	EX SMOKER	Y / N
	NEVER SMOKED TOBACCO	Y / N

ALCOHOL INTAKE: PLEASE COMPLETE FAST SCORE QUESTIONNAIRE ATTACHED

ALLERGIES: Please list below any Medicine, Substance, Food, Animal etc to which you know you have an allergy.

EXERCISE:

Do you take any regular exercise. Please choose from the following list.

- A Ex. impossible
- B Enjoys light exercise
- C Moderate exercise
- D Enjoys heavy exercise
- E Aerobic 1/Week
- F Aerobic 2/Week
- G Aerobic 3+/week

FAMILY HISTORY: Do you or any of your close relatives have any of the following illnesses or conditions:

CONDITION	PLEASE GIVE DETAILS
CANCER	YES/NO
RAISED LIPIDS (Cholesterol)	YES/NO
HIGH BLOOD PRESSURE	YES/NO
HEART DISEASE (Under 60)	YES/NO
HEART DISEASE (Over 60)	YES/NO
CVA/STROKE	YES/NO
DIABETES	YES/NO
DIABETES (In Pregnancy)	YES/NO
ASTHMA	YES/NO
EPILEPSY	YES/NO
THYROID PROBLEMS	YES/NO
OTHER DISORDERS	YES/NO

DIET

- A VEGETARIAN
- B VEGAN
- C WEIGHT REDUCING DIET
- D LOW FAT DIET
- E LOW SALT DIET
- F HIGH FIBRE DIET
- G GLUTEN FREE DIET
- H LOW CHOLESTEROL DIET
- I LACTOSE FREE DIET
- J NOT ON SPECIAL DIET

DATE QUESTIONNAIRE COMPLETED -----

WOMEN ONLY:

PERIODS:

CONTRACEPTION:

Do you use Contraception Yes/No

If Yes, what sort -----

PREGNANCY:

Please list all the Pregnancies you have had and dates of birth:

Date of Birth

CHILD HEALTH QUESTIONNAIRE

FULL NAME: -----

ADDRESS: -----

----- POST CODE: -----

TELEPHONE NUMBER: ----- DATE OF BIRTH: -----

ETHNIC GROUP:

- | | | | |
|-----------------|---------------------|---------------|------------------------|
| A British/mixed | F White & Asian | K Other Asian | P Other Ethnic |
| B Irish | G Other mixed | L Caribbean | Q Ethnicity not stated |
| C Other White | H Indian/British | M African | |
| D W&B Caribbean | I Pakistani/British | N Other Black | |
| E W&B African | J Bang/Brit Bang | O Chinese | |

ALLERGIES: Please list below any Medicine, Substance, Food, Animal etc to which you know your child has an allergy:

CHILDHOOD IMMUNISATIONS:

Age Due	Immunisation	Date Given
2 months	Diphtheria/Tetanus/Whooping Cough, Polio, Hib, Pneumococcal	
3 months	Diphtheria/Tetanus/Whooping Cough, Polio, Hib, Men C	
4 months	Diphtheria/Tetanus/Whooping Cough, Polio, Hib, Men C, Pneumococcal	
12-18 months	Measles, Mumps, Rubella (MMR), HIB, Men C	
3-5 years	Diphtheria, Tetanus, acellular Pertussis, Polio, MMR2	
Girls 12-13 yrs	HPV	
13-18 yrs	Dip, Tet, Polio	

FAMILY HISTORY: Do you or any of your close relatives have any of the following illnesses or conditions:

CONDITION:

PLEASE GIVE DETAILS

DIABETES-----

HEART DISEASE-----

HIGH BLOOD PRESSURE-----

STROKE-----

RAISED LIPIDS (Cholesterol)-----

ASTHMA-----

Have your parents, or yourselves, suffered from any chronic illness in the past. If yes, please give details.

Mother Father

If there is any other information you feel is relevant, please continue overleaf.

DATE QUESTIONNAIRE COMPLETED

REMEMBER: PLEASE BRING YOUR RED BOOK TO YOUR NEW PATIENT APPOINTMENT