



NEW PATIENT QUESTIONNAIRE

One form should be completed for each patient who is registering – please complete in BLOCK CAPITALS

When you register with the practice, you will be given a new patient medical appointment with the practice nurse or the doctor if you take medication – please note that this may not be for 2-3 weeks. Please ensure you have plenty of medication from your previous practice until you attend this appointment.

First name(s): **Surname:**

Marital status: Single Married Widowed Divorced Separated Living with Partner

Address:
.....

Postcode: **Date of birth:**

Telephone number: Home Mobile.....

Ethnicity: White White other Mixed Mixed other Chinese
Asian or Asian British Asian other Black or Black British Black other
Other ethnic group

Please give an emergency contact/next of kin:

Name **Tel No:**

Address:

If you take medication regularly please attach a copy of a recent repeat medication slip for information.

Do you have a disability? Yes No

Do you suffer from any allergies? Yes No If yes, please give details

LADIES – Do you know the date and result of your last cervical screening test?

Date: **Result:**

CHILDREN UNDER 5

Under 5's do not routinely get a new patient appointment, but please make an appointment to see the doctor if there is anything you would like to discuss. If you are not the parent or legal guardian of the child, please give us

Your name: **Relationship to the child**

	1 st immunisations	2 nd immunsations	3 rd immunisations	Preschool Booster
DTaP/IPV/Hib
Men C
MMR
Pneumococcal