

Brookfields Health Centre & Cherry Hinton Medical Centre
New Patient Confidential Questionnaire

Please complete this confidential questionnaire which will help our Doctors and Nurses appreciate your healthcare needs.

PERSONAL DETAILS:		
Surname: (In CAPITALS please)	First Name: (In CAPITALS please)	
Middle Name(s): (In CAPITALS please)	Previous Name: (In CAPITALS please)	
Home Address:		
Town:	County:	Postcode:
Home Tel No:	Daytime Tel No:	Mobile No:
Date of birth:	Place of birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation:	Single / Married / Divorced / Separated / Remarried / Widowed / with Partner	
	Who would you like us to contact if you have an emergency? Name: _____ Tel No: _____	

CHILD REGISTRATION:		
Mother's Name:	Address:	Tel No:
Father's Name:	Address:	Tel No:

MEDICAL HISTORY:					
Previous Doctor's Name and Address:					
Previous illnesses / operations / hospital admissions (with dates and your age at the time):					
Immunisations – Have you had the following vaccinations and if so, when? (please circle)					
Tetanus:	Yes / No	Date	Oral Polio:	Yes / No	Date
MMR:	Yes / No	Date	Rubella: (females only)	Yes / No	Date

CURRENT MEDICAL DETAILS:	
Do you have any current health problems?	Yes / No (please list)
Please list any medication you take, including those bought over the counter:	
Do you know what each medication you take is for?	Yes / No

ADDITIONAL MEDICAL INFORMATION:

What allergies do you have, if any?

What is your height? _____ What is your weight? _____

Do you smoke Yes / No If yes, how many per day? _____

Have you smoked before? Yes / No If yes, when did you stop? _____

Would you like help stopping smoking? Yes / No

Do you know your last blood pressure reading? Yes / No

If so, what was it: _____ / _____ Approx. date: _____

Do you drink alcohol? Yes / No

How often do you drink alcohol? Never Monthly 2-4 times 2-3 times 4+ times
month week weekHow many standard alcoholic drinks do you have on a day when you are drinking? 1-2 3-4 5-6 7-8 10+ How often do you have 6 or more standard drinks on one occasion? Never Less than Monthly Weekly Daily or
monthly almost daily**FAMILY MEDICAL HISTORY:**

Do any illnesses run in the family such as: Diabetes, Heart Disease, Blood Pressure, Asthma, Glaucoma Stroke? (please add age at onset of serious illness or death)

If Alive:**If not Alive:**

Father

Mother

Brothers

Sisters

SOCIAL INFORMATION:

Are you caring for a partner / relative / friend / or person who cannot manage without help because of illness / age / disability of any kind? Yes / No

FEMALE PATIENTS ONLY:

Have you ever had a cervical smear? Yes / No If yes when _____ What was the result? _____

LANGUAGE: What is your first spoken language? _____		
ETHNICITY: How would you describe your ethnic group? Please tick one of the following		
White	White British / Mixed British (inc. English Scottish Welsh) Irish Other White background (please specify) _____	<input type="checkbox"/> <input type="checkbox"/>
Mixed	White and Black Caribbean, White and Black African, White and Asian, Other Mixed background (please specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asian or Asian British	Indian or British Indian Pakistan or British Pakistani Bangladeshi or British Bangladeshi Other Asian background (please specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Black or Black British	Caribbean African Other Black background (please specify) _____	<input type="checkbox"/> <input type="checkbox"/>
Chinese	Chinese Other chinese background (please specify) _____	<input type="checkbox"/>
Other ethnic group	Other ethnic group (please specify) _____	

SURGERY INFORMATION:

The surgeries open Monday to Friday between the hours of 08:00 and 12:30 and 13:30 and 18:00

Details of our services and staff can be found on our web site and in our practice leaflet.

Signature of patient _____ Date _____

Thank you for taking the time to complete this form

<i>Office Use Only:</i>			
ID Check: Photo _____	Address _____	Staff Initials _____	Date _____