NEWBOLD VERDON MEDICAL PRACTICE / MARKET BOSWORTH SURGERY

NEW PATIENT QUESTIONNAIRE

Full Name:	Name Used (if different):	
Address:	Previous Address:	
Postcode:	Postcode:	
Tel No:	Mobile No:	
Date of Birth:	Occupation:	
Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐		
Previous Doctor Name & Address:		
Ethnicity:	First language spoken:	Religion:
We are trying to improve communication with our patients. We want to make sure you can read and understand the information we give to you. If you need information in an accessible format, i.e. larger print letters, hearing loop, sign language interpreter etc. please speak to a receptionist or the clinician you see for your new patient medical and we will make a note of this on your records.		
Do you suffer from, or have had any of the following: Angina ☐ Heart Attack ☐ Diabetes ☐ Asthma ☐ Hypertension ☐ Stroke ☐		
Any other illnesses or operations: (Please give dates where possible)		
Present Repeat Medication: (Please give details)	Allergies:	
Family History – please tick if a close relative has had any of the following: Coronary Heart Disease ☐ Heart Attack / Angina under the age of 60 ☐ Asthma ☐		

Diabetes ☐ Hypertension ☐ Stroke ☐ Stroke below the age of 60 ☐

If you ticked any of the above, can you tell us what relation they are / were to you – e.g. mother / uncle:

Any other family conditions we should be aware of:

Alcohol Intake – Please complete separate questionnaire and return with this one

Smoking History:

Non Smoker ☐ Previous Smoker ☐ Date Stopped:

Present Smoker ☐ Amount per day:

Would you like advice / help with stopping smoking? Yes ☐ No ☐

Date of last Tetanus Injection: Not Known ☐

Do you care for anyone who is unable to look after themselves at home? Yes □ No □

If yes, can you tell us who they are: Relative □ Friend □ Neighbour □

Do you have anyone that is a carer for you? Yes □ No □

If yes, can you tell us who they are: Relative □ Friend □ Neighbour □

Do you have Private Medical Insurance: Yes ☐ No ☐

WOMEN ONLY

Date of last Cervical Smear Test: Normal ☐ Abnormal ☐

Do you use contraception: Yes ☐ No ☐

If "Yes", please specify type:

Summary Care Record

The surgery is now live for Summary Care Records (information included in New Patient Pack) – please tick below to confirm whether you wish to Opt in or Opt out of having this:-

I wish to Opt In and have an Enhanced Summary Care Record ☐

I wish to Opt Out and NOT have a Summary Care Record ☐