

FEMALE

HATHAWAY MEDICAL CENTRE NEW PATIENT QUESTIONNAIRE

To be completed by all new patients over the age of 14. **Failure to complete any part of this form may result in your registration being delayed.**

FULL NAME.....

ADDRESS.....

..... POST CODE.....

HOME TELEPHONE..... MOBILE

EMAIL ADDRESS

PERMISSION TO USE MOBILE FOR CONTACT No. Yes

PERMISSION TO USE E-MAIL FOR LETTERS ETC No. Yes

SEX –Female DOB/...../.....

MAIDEN NAME.....

Next of Kin: Name..... Contact number:.....

PERSONAL HISTORY

Are you: Single/Married/Separated/Divorced/Widow/Widower/Cohabiting

Children: Names & Date of Birth

.....
.....

HEALTH HISTORY

Weight Height Exercise – None/Light/Moderate/Heavy

Have you ever smoked? No Yes Do you smoke now? No. Yes

If you are an ex-smoker please give us the date you stopped smoking.....

If 'yes' how many Cigarettes/Cigars per day or ozs. tobacco per week.....

We recommend smokers consider giving up, would you like support you to do this? No. Yes

What is your average intake of alcohol per week?

Pints of beer/cider etc. Glasses of wine..... Measures of spirits

NB: MUST BE COMPLETED

Are you addicted to any drugs or to alcohol

If yes – please detail

Have you had addiction problems in the past

.....

Please list, with dates, any major illnesses or operations you have had:

.....
.....
.....

If you are currently taking any repeat medication, please ensure you have at least 2 weeks supply before you register at Hathaway, you will need an appointment with a GP for a review of your current repeat medication. You will need to bring a copy of your repeat prescription or the medication you take before any medication will be issued.

Are you allergic to any medications? If 'Yes' please give details:-

Drugs

What Reaction

.....

FAMILY HISTORY

Have you or any close relatives suffered from any of the following?

Problem	You	Family Member/s	Age at onset
Heart Attack/Angina			
High Blood Pressure			
Diabetes			
Epilepsy			
Psychiatric disorder			
Glaucoma			
Thyroid Disease			
Cancer (Breast/Bowel/Lung)			
Asthma			
COPD			

FOR WOMEN

What was the date of your last smear? - approximately.....

Was it normal Yes /No. Were you told when you should have another

CONTRACEPTION: please circle Pill/Coil/Implant

ARE YOU A CARER Do you care for a disabled or chronically ill person - if so please give brief details.....

Would you like this information passed onto Social Services who can offer support for carers? Y/N

ETHNICITY

We are required to collect ethnicity information on all of our patients. Please tick one of the following boxes

White		Mixed race		Asian	
Caribbean		African		Chinese	
Japanese					

FIRST LANGUAGE.....

Signature.....Date.....

These details will be added to your medical records at registration Thank you