THE NIGHTINGALE PRACTICE NEW PATIENT QUESTIONNAIRE
ADULT AND CHILDREN >15YEARS

It may be several weeks before we receive your medical records from your previous GP. Please try and complete this questionnaire in full to give your new doctor any important information about your health. All information will be kept strictly confidential.

PERSONAL DETAILS

First Name/s……Family Name/Surname……

Middle Name/s……Date of Birth……Sex Male/Female (please circle)

Address……..

……Post code……

Tel no.(Home)……(Work)……(Mobile)……

Would you like us to send a text message to your mobile to remind you of your appointment? *Yes / No*

Have you ever been registered at this practice? *Yes / No*

Next of Kin……Relationship……..Tel no……

Are you: - Employed/Unemployed/Studying/Retired/Full time parent (please circle)

Are you a carer? *Yes/No* Who for……...Relationship……..Tel no……

Do you have a carer? *Yes/No* Relationship……Tel no……

ETHNICITY

Please circle the ethnic group which most closely matches your ethnicity. This information is used to plan provision of our services e.g. advocacy services.

(Asian or Asian British) Bangladeshi	(Black or Black British) Other	(White) British
(Asian or Asian British) Indian	(Mixed) Other	(White) Irish
(Asian or Asian British) Other	(Mixed) White and Asian	(White) Other
(Asian or Asian British) Pakistani	(Mixed) White and Black African	
(Black or Black British) African	(Mixed) White and Black Caribbean	
(Black or Black British) Caribbean	(Other) Chinese	

Other ethnicity please specify……

Country of Birth…… **Date (or year) of entry to UK**……

If you require an interpreter please specify your language ……

MEDICAL HISTORY

Have you ever had any of the following?

Diabetes	*Yes / No*	Asthma	*Yes / No*	High Blood Pressure	Yes */ No*
TB	*Yes / No*	Heart Disease	Yes */ No*	High Cholesterol	*Yes / No*
Stroke	*Yes / No*	Epilepsy	*Yes / No*		

Any other major illness/disease……

……..

FAMILY HISTORY

Has anyone in your immediate family had any of the following?

High Blood Pressure	*Yes / No*	High Cholesterol	*Yes / No*	Diabetes	*Yes / No*
Asthma	*Yes / No*	Heart Disease	*Yes / No*	Stroke	*Yes / No*
Breast cancer	*Yes / No*	Bowel cancer	*Yes / No*	TB	*Yes / No*

PLEASE TURN OVER

VACCINATIONS

Have you had a Tetanus Booster within the last 10 years? *Yes / No* Date given……..
Have you had a Polio Booster within the last 10 years? *Yes / No* Date given……..
If you are under 25 years have you had a Men C vaccination? *Yes / No* Date given……

MEDICATIONS

Do you take any regular medication? *Yes / No* Please give us the names……

……..

……..

……..

……..

……..

……..

Are you allergic to any medicines? *Yes / No* Which ones?.....

SMOKING

Do you smoke? *Yes / No* How many per day?.....

Have you ever smoked? Yes/No If so when did you stop?.....

ALCOHOL:

How often do you have a drink that contains alcohol: Never Monthly 2-4 times week 4 + week?
How many standard alcoholic drinks do you have in a day: 1-2 3-4 5-6 7-9 10 +
How often do you have 6 or more drinks on one occasion: never less than monthly monthly daily?

WHAT IS YOUR WEIGHT AND HEIGHT? Scales are available at reception

Weight	……KG (scale)	……..stone	……lbs
Height	……CM (attached to scale)	……feet (ft)	……Inchs

NEW PATIENT CHECK: HIV SCREENING and TB SCREENING

All new patients will require a new patient health check with a member of our nursing team.
We encourage HIV screening for ***all*** new patients, this can now be done as an instant finger-prick test. All patients will be offered an HIV test at the new patient check, please indicate if you are happy to be screened? *Yes / No*

Have you moved to the UK in the last 5 years? Recent immigrants from certain countries are also eligible for TB screening – ask at your New Patient Check. **Date of entry to UK**……..

WOMEN ONLY

When was your last smear…… Where was it taken…… Result……

Have you ever had an abnormal smear *Yes / No* Date ……Result……..

Were you treated in the colposcopy clinic? *Yes / No*

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE