

STRAND MEDICAL GROUP "NEW PATIENT" QUESTIONNAIRE

Please fill in the details requested in this questionnaire as fully as possible and return to the Strand Medical Group with your registration documents.

PERSONAL DETAILS

SURNAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ SEX – Please tick ✓ FEMALE: MALE:

NHS NUMBER: _____

OCCUPATION: _____

ADDRESS: _____

POST CODE: _____

TELEPHONE HOME: _____ WORK: _____

MOBILE: _____

EMAIL ADDRESS: _____

NEXT OF KIN NAME: _____

CONTACT NUMBER: _____

Occasionally it may be necessary for the surgery to contact you by telephone, for example to change an appointment. If you are not available to take the call, may we leave a message with a third party, on an answer phone or on voicemail? No medical information would be given or disclosed.

Please specify as applicable:

I give permission for the surgery to leave a message: * With a third party Home number Mobile voicemail

* Please circle all relevant

I give permission for the surgery to text to my mobile: YES: NO:

Please note that consent to all the above will be assumed if no options are marked.

This arrangement will remain in force until you advise us in writing that you wish to change it.

Ethnicity - Please tick ✓

- | | | |
|---|--|---|
| <input type="checkbox"/> White British | <input type="checkbox"/> British Indian | <input type="checkbox"/> Ethnic category not stated |
| <input type="checkbox"/> Mixed British | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Black African |
| <input type="checkbox"/> Irish | <input type="checkbox"/> British Bangladeshi | <input type="checkbox"/> Other black background |
| <input type="checkbox"/> Other white background | <input type="checkbox"/> Black British | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> Other Asian background |
| | | <input type="checkbox"/> Other mixed background |

Are you a carer?

YES:

NO:

If yes, please give details of the person you care for: _____

Do you have a carer?

YES:

NO:

If yes, please give details of the person who cares for you: _____

Are you allergic to any medicines?

YES:

NO:

If yes, please specify: _____

Are you allergic to anything else?

YES:

NO:

If yes, please specify: _____

LIFE STYLE QUESTIONS

Height: _____

Weight: _____

Waist circumference: _____

Do you smoke? YES: NO: Never smoked: Passive: Smoked in the past:

Please tick ✓ Cigarettes Tobacco Pipe Cigars

How much per day / week: _____

Do you drink any alcohol? YES: Please specify how many units on a typical day NO:

1 – 2

3 – 4

5 – 6

7 – 8

9 +

1 unit = ½ of beer or 1 measure of spirits or 1 small glass of wine

Do you take any regular exercise?

YES:

NO:

If yes, please specify: _____

Name: _____ Signature: _____ Date: _____