



Strand Medical Group

STRAND MEDICAL GROUP 'NEW PATIENT' QUESTIONNAIRE

Please complete this questionnaire and return it to the Strand Surgery with your registration documents.

DATE COMPLETED:

SURNAME:

FIRST NAMES:

DATE OF BIRTH:

SEX – Please Tick ✓ : [] Male [] Female

ETHNIC ORIGIN - Please Tick ✓ :

- | | |
|--|--|
| <input type="checkbox"/> African | <input type="checkbox"/> Other Asian Background |
| <input type="checkbox"/> Bangladesh / British Bangladesh | <input type="checkbox"/> Other Black Background |
| <input type="checkbox"/> British / Mixed British | <input type="checkbox"/> Other Mixed Background |
| <input type="checkbox"/> Caribbean | <input type="checkbox"/> Other White Background |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ethnic Category not stated | <input type="checkbox"/> Pakistani / British Pakistani |
| <input type="checkbox"/> Indian / British Indian | <input type="checkbox"/> White and Asian |
| <input type="checkbox"/> Irish | <input type="checkbox"/> White and Black African |
| | <input type="checkbox"/> White and Black Caribbean |

ADDRESS:

.....

.....

TELEPHONE NUMBER HOME: WORK

MOBILE:

Please take your Blood Pressure recording on our automated machine in westcourt Medical Centre Reception area and attach it to this form for our records. { }

ABOUT YOUR FAMILY: Does any member of your family have any of the following conditions?

Condition	Relationship	Age at Diagnosis
Heart Problems?		
Stroke / CVA?		
High Blood Pressure?		
Asthma?		
High Cholesterol?		
Epilepsy?		
Cancer?		
Glaucoma?		
Diabetes?		

Please record your current **Height** **Weight**

Waist Measurement

Please use scales at the surgery if no other scales are available to you.

ARE YOU ON REGULAR MEDICATION? Please Tick ✓ Yes No

If yes, please ask the receptionist to book you an appointment with the doctor and bring your repeat slip from your previous doctor with you to that appointment.

ARE YOU ALLERGIC TO ANY DRUGS? Please Tick ✓ Yes No

If YES, please specify:

ARE YOU ALLERGIC TO ANYTHING ELSE? Please Tick ✓ Yes No

If YES, please specify:

DO YOU SMOKE? Please Tick ✓ Never Ex-Smoker

Current Passive Smoker

If you are a Current Smoker, how much do you smoke?

If you are an Ex-Smoker, when did you stop smoking?

HOW MUCH ALCOHOL DO YOU DRINK EACH WEEK?.....
(e.g.: 1 pint beer=2 units 1 small glass of wine = 1 unit)

HOW MUCH EXERCISE DO YOU TAKE?.....

ARE YOU A CARER? YES/NO* (*Please delete as applicable)

If YES, please give details

DO YOU HAVE A CARER? YES/NO* (*Please delete as applicable)

If YES, please give details

Occasionally it may be necessary for the surgery to contact you by telephone, for example to change an appointment you have or pass on a message from the doctor. We would like to ask if you would be happy for us to leave a message with a third party or on voicemail, if you are not available to take the call, asking you to ring the surgery back to pick up the message.

No medical information would be left or disclosed.

Please delete as appropriate and sign and date below;

I am / am not happy for you to leave a message on my (Please Tick ✓):

Home Telephone [] Mobile Number []

Signature: Date:

THIS ARRANGEMENT WILL REMAIN IN FORCE UNTIL YOU ADVISE US IN WRITING THAT YOU WISH TO CHANGE IT.

We do not automatically carry out a new patient health check at this surgery. If you should feel that you would like this done please contact Angie Gilbert Head of Nursing on 01903 243351 Monday to Friday between 2.00pm & 5.00pm to arrange an appointment.

Thank you for completing this form

For Admin use only

Registering GP:

Emis Number: