| **FOR PRACTICE USE ONLY** |
| --- |
| **Named GP Code [ ]** **DCRA Unticked [ ]** **Patient EMIS ID No:** |

***Welcome To Wickham Park Surgery***

***New Patient Questionnaire***

Please use block capitals & **BLACK INK** to complete this form

Today’s date: ……………… Date of Birth: …………...........................

Surname: ……………………………… First Name: ………………………………………

Address: …………………………………………………………………………………………………

………………………………………………………………….. Post Code: ……………………….

Telephone Home: ………………………………………………………………………………….

Telephone Mobile: …………………………………………………………………………………

Email Address: ……………………………………………………………………………………….

**Sex:** Male: [ ]  Female: [ ]  Occupation: ………………………………………………

Country of birth: ……………………………………………………………………………………..

Date if entry to UK (if applicable): …………………………………………………………..

**Next of Kin**

Name: ……………………………………………………………………………………………………

Contact Tel No: ……………………………………………………………………………………..

Relationship to you? E.g. Mother, Brother …………………………………………….

**Are you a Carer?** No: [ ]  Yes: [ ]  Please give name of person you care for ………………………………………………………………………………………………………………

**Do you have a Carer?** No: [ ]  Yes: [ ]  Please give name and contact number ………………………………………………………………………………………………………………

**HEALTH QUESTIONS**

**Are you a smoker?** No: [ ]  Yes: [ ]  If Yes, how many a day …………………..

**Have you ever smoked?** No: [ ]  Yes: [ ]

If yes please give the date you stopped? …………………………

Were you a Heavy [ ]  Moderate [ ]  or Light Smoker? [ ]

**Is there anything unusual about your diet?** …………………………..

**How much exercise do you take?** …………………………………........

**MEDICAL HISTORY**

Please list any operations, hospital admission or serious illness you have had or have at present:

Date: Details:

**Height: ………………** **Weight: ………………..** **Waist Circumference: ……………….**

**MEDICATION**

**Please list any medications that you take on prescription:**

Name of Medication: How often taken:

**ALLERGIES**

Please list any medicines or foods you are allergic to:

**FAMILY HISTORY**

Please list any serious illness of living relatives and where known the cause of death of parents or brothers or sisters.

**Relation: Age Illness/Cause of death**

***WOMEN ONLY***

**Have you had any pregnancies?** No: [ ]  Yes: [ ]

If yes, please give details of how many: Male: ……… Female: ………

Miscarriages: ………

**Do you use any form of contraception?** No: [ ]  Yes: [ ]

Not applicable: [ ]

If yes please state type: …………………………………

**Please give date and place of last Cervical Smear:**

Date: ………………………… Place: ………………………………

**Have you ever had a mammogram** No: [ ]  Yes: [ ]  or other breast cancer screen? No: [ ]  Yes: [ ]  If yes, please state place……………………………………..

**IMMUNISATION HISTORY**

***To be completed for all patients***. Please state which immunisations you have had e.g. Tetanus, diphtheria, polio, whooping cough, MMR, rubella or German measles, typhoid, etc.:

**Immunisation: Date:**

***Patients aged 18 years or under***

Please enter Name & Address of **Nursery, School or College**

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**ETHNIC GROUP** - Please tick as appropriate:

**White**

British First Language: ………………….

Irish First Language: ………………….

Other White Background First Language: ………………….

**Black**

British First Language: ………………….

Black African First Language: ………………….

Black Caribbean First Language: ………………….

Other Black First Language: ………………….

**Asian or British Asian**

British Asian First Language: ………………….

Asian/Indian First Language: ………………….

Asian/Pakistani First Language: ………………….

Asian/Bangladesh First Language: ………………….

Other Asian First Language: ………………….

**Other Ethnic Group**

Chinese First Language: ………………….

Other Ethnic Group First Language: ………………….

**Mixed**

White & Black African First Language: ………………….

White & Asian First Language: ………………….

White & Black Caribbean First Language: ………………….

Other mixed background First Language: ………………….

**Not Stated**

Ethnic Group not stated First Language: …………………..

Religion ……………………….

If your first language is not English do you require an interpreter?

Yes [ ]  / No[ ]  Language………………………………………..

***Please return forms to the surgery receptionist. If you are applying for Patient Access you will be asked for PHOTO ID such as your passport or driving licence***

***Data recorded in this questionnaire will be stored in accordance with the data protection act and will be used only by Wickham Park Surgery and Bromley CCG.***