**NEW ADULT PATIENT QUESTIONNAIRE**

As you are a new patient and it may take a while for us to receive your original medical records, we would be grateful if you would complete this questionnaire in order to give us a brief medical history. It will be strictly confidential. A Practice booklet for new patients is available to download from our website and also available at Reception, on request.

**Your Personal Details**

Name ……………………………………… Date of Birth ………………….. Postcode ……………………

Telephone no (home) …………………….. (work) …………………………. Mobile:……………….………

**The surgery operates a text messaging service and will send text reminders for appointments and also other health related information. Patients can also cancel appointments by replying to the text. If you do not wish to be contacted in this way you can opt out.** Text Messaging? YES/NO

Marital status: ………………………………… Email address ……………………………………

Are YOU a Carer? YES/NO Do YOU have a carer ? YES/NO

**Name of next of kin/emergency contact details:**

Name of person……………………………… Their relationship to you ……………………………………….

Their contact telephone number/s: ….……….………………………………….………………………………………………

Their address (inc postcode please): …………………………………………………………………........................

**Lifestyle:**

Smoking information: Never smoked Ex-Smoker How many did you smoke a day? ………

 Current smoker How many do you smoke a day? …………

***(You can get help to stop smoking by booking an appointment with one of our Stop Smoking advisors)***

How much alcohol do you drink a week? …………………………………………………

**Medical History:** Please list, with date and year, any serious mental or physical:

 Illness: …………………………….……………………………………………………………………………………………….

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

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

 Operations: …………………………………………………………………………………………………….................

 ………………………………………………………………………………………………………………………………………….

 Injuries: ……………………………………………………………………………………………………………………………

Are you on any current medications? (Please list tablets and/or other prescription items) …………………………

…….……………………………………………………………………………………………………………………………………………………………….

Do you have any allergies, eg. Penicillin? (please specify) …………………………………………………..…………..