**Station Road Medical Practice**

**New Patient Questionnaire**

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| **Name:** |  | **Date of Birth:** |  |
| **Address:** |  |
| **Telephone:** |  | **Mobile:** |  |
| **Email:** |  | **Occupation:** |  |
| **Name & Address of** **Previous Doctor:** |  |
| **Next of Kin:** |  |
| **Have you been registered with our practice in the past?** | **Yes** |  | **No** |  |

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| **Current Medication** |
| Please indicate any current medication you are taking |
| Name | Strength | Dosage |
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| **Illnesses, Accidents, Operations** |
| Please indicate any significant past illnesses, accidents or operations  | Date |
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| **Allergies** |
| Please indicate any allergies you have |
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| **Your Health** |
| Smoking Status: | Smoker | Ex-Smoker | Never Smoked |
| Height: |  | Weight: |  |
| Weekly Units of Alcohol Consumed: |  |

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| **Family History** |
| Please indicate if you or any family member have had any of the following conditions: |
|  | You | Family Member |
| Heart Disease |  |  |
| Diabetes |  |  |
| Asthma |  |  |
| COPD |  |  |
| Hypertension |  |  |
| Stroke |  |  |
| Epilepsy |  |  |
| Hypothyroidism |  |  |
| Kidney Disease |  |  |
| Cancer |  |  |
| Osteoporosis |  |  |

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| **Carers** |
| Please indicate if you are a carer and who you care for in your family? |
| Family Member: |  |

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| **Vaccination History** |
| Please indicate if you have received any of the following vaccinations in the past 10 years: |
| Vaccination | Date |
| Diptheria/Tetanus/Polio |  |
| MMR |  |
| Whooping Cough |  |
| Influenza |  |
| Pneumococcal |  |
| Hepatitis A |  |
| Hepatitis B |  |
| Travel Vaccines |  |

**Thank you for completing this questionnaire**