**Station Road Medical Practice**

**New Patient Questionnaire**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 | | | |
|  | | | |
|  | | | |
| **Your Health** | | | |
| Smoking Status: | Smoker | Ex-Smoker | Never Smoked |
| Height: |  | Weight: |  |
| Weekly Units of Alcohol Consumed: | |  | |

|  |  |  |
| --- | --- | --- |
| **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 |  |  |

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

|  |  |
| --- | --- |
| **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**