NEW PATIENT MEDICAL QUESTIONNAIRE

Mr/Mrs/Miss/Ms Name : _____ **D.O.B :** _____

Address : _____ **Tel. No. :** _____

_____

Past/Present Medical History :

Heart Disease	☐	Hypertension	☐
Diabetes	☐	Stroke	☐
Asthma	☐	Other	☐

Please specify _____

Family History :
Is there any of the following in your family...

		Which family member?	Before the age of 65?
Heart Disease	Y/N	_____	Y/N
Diabetes	Y/N	_____	Y/N
Hypertension	Y/N	_____	Y/N
Stroke	Y/N	_____	Y/N
		_____	

Please supply us with details of present medications

Drug Reactions or Allergies : _____

_____

_____

Next of Kin : _____ **Tel :** _____

Smoking History :

Never smoked tobacco	☐	
Ex. smoker	☐	Approx. year stopped : _____
Current Smoker	☐	

Occupation ----------

Details of previous residence outside UK

ARE YOU A CARER? Y / N if you are a carer, who do you care for?

DO YOU HAVE A CARER? Y / N if you do, who cares for you?

□ **If you do not wish to give this information, tick here**

Do you need an interpreter or sign language support? Yes No
If you do need an interpreter what language do you speak?
Please state …….
What is your ethnic group?
Choose **ONE**
A White
□ Scottish
□ English
□ Welsh
□ Northern Irish
□ British
□ Gypsy/Traveller

European Origin (please state**).....**

African Origin (please state)**.....**

Asian Origin (please state)**.....**

Other ethnic group (please state)**.....**

□ **If you do not wish to give this information, please tick here**

For office use

Registration document completed in full	☐	
Registration document signed	☐	
New patient appointment made	☐	date…….
Name in book	☐	
Sample bottle given	☐	
New patient booklet given	☐	
Advise pharmacist of medications	☐	
New Patient template completed	☐	