THE LADE MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE

We would appreciate that you as a newly registered patient complete and return the attached questionnaire.

As a new patient we recommend that you make an appointment to see a doctor to have a routine health check when you register. This allows you discuss any health needs which you have, and it allows us to get to know you and to do a few simple health checks.

Mr/Mrs/Miss/Ms/Dr .... Date of Birth .....

Address ..... Home Telephone No .....

..... Mobile Telephone No .....

..... Today's Date .....

Postcode .....

Health History

Please record any significant past illnesses, accidents, operations or other hospital admissions including if possible the date on which they occurred or started.

Date

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Please provide a full list all medication that you take. You will get this information from your previous prescription slip (please attach if you have one) or you may need to contact your previous GP. **Please note that we will require 2 working days to process any prescription request. Please do not leave it until you have no medication left.**

Drug Name	Strength	Dose
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Please allocate a Pharmacy to collect your medication from:

Please provide details of any medication you buy over the counter:

Do you have any allergies?

P.T.O.

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Personal Profile

What is your occupation?	
What is your marital status?	
Do you smoke?	Yes/No
If yes - how many per day?	
- would you like help to stop smoking?	Yes/No
Do you drink Alcohol?	Yes/No
If yes - how many units would you drink each week? (1 unit = 1 small glass wine/ ½ pint beer/ 1 standard measure of spirits)	
What regular exercise do you undertake?	
Are you a Carer? Do you have a Carer?	Yes/No Yes/No
Please state name and contact number of Next of Kin	
Please state your first language and if you speak any other languages (this will help with translators, where needed)	

Family History

Please list any illness that run in your family		
Have any close family members suffered from any of the following:		
Diabetes	Yes/No	Relationship to you
High Blood Pressure	Yes/No	Relationship to you
Stroke	Yes/No	Relationship to you
Heart Disease	Yes/No	Relationship to you

Would you be happy for the practice to contact you by text/email message? Yes/No

Thank you for taking the time to fill in the questionnaire. Please return the completed form to reception.