Marfleet Group Practice

New Patient Questionnaire

Surname: Previous Name:

First name(S) Male Age

Date of Birth: Female

Place of Birth: NHS No:

Address:

Post Code: Telephone No:

Do you given consent for SMS text messages YES /NO Mobile No:

Next of Kin: Telephone No:

Do you suffer from any allergies? Yes No

Please list them:

Are you a carer for someone:	Yes	No	Is someone a carer for you :	Yes	No

If you answered Yes to either of the last two questions

Our receptionists will provide you with a Carers Questionnaire.

Do you smoke	Yes	No	How many per day:	
Have you given up	Yes	No	If Yes give Date:	
Would you like support and information on giving up?	Yes	No		

Please advise us of your first Language English Other (Please specify)

Which Ethnic Origin Group do you belong to? Please tick

White British		Other ethnic non-mixed	
Black Caribbean		Other ethnic mixed origin	
Black African		Vietnamese	
Black other non-mixed origin		Other Black ethnic group	
Black other mixed		Irish Traveller	
Indian		Other Asian ethnic group	
Pakistani		Ethnic group not given patient refused	
Chinese			

How often do you have a drink containing alcohol?		How many drinks containing alcohol do you have on a typical day when you are drinking?		How often do you have six or more drinks on one occasion?	
Never		1 or 2		Never	
Monthly or less		3 or 4		Less than monthly	
2-3 times a month		5 or 6		monthly	
2-3 times a week		7,8 or 9		Weekly	
4 or more times a week		10 or more		Daily or almost daily	

Please tick it you have had any of the following:

High Blood Pressure		Asthma		Angina	
Heart Attack		Tia		Stroke	
Depression		Diabetes		Manic Depression	
Schizophrenia		COPD		Epilepsy	
Underactive Thyroid		Learning Difficulties		Kidney Disease	

Please list your current medication below:

Name of tablet	Dose	How often do you take it	Reason

We would appreciate a copy of your repeat prescription list for our records. If you are on regular medication you will need an appointment with our nurse or Doctor.

Do you take ALL the medicines listed on your repeat list?

If not, which do you no longer take?

Do you know what each of your medicines is for and when to take them?

Do you ever forget to take your medicines?

Do you experience any problems opening the packaging or taking your medicine?

Do you take any other medicines? If so please tell us what they are:

Thank you for completing this form, the information will be entered onto our clinical system to help the Doctors and nurses give you the best treatment/Advice possible and remain completely confidential.