

Coventry Road Practice

New Patient Questionnaire



Welcome to Coventry Road Practice. We will be getting your old medical records from your previous doctor. This may take a number of weeks, so in order to look after you it would be helpful if you could answer the following questions.

Personal Details

Name

D.O.B. / /

Telephone (Home)

(Mobile)

Email

Preferred method of contact:

Home tel Mobile Email Post

Occupation:

.....

Family History

Have any close relatives had:

a) Stroke Yes No

b) Heart disease, heart
attack or angina Yes No

c) Diabetes Yes No

d) Asthma Yes No

e) High Blood Pressure Yes No

If yes which relative and their age:

.....

Other illnesses running in the family

.....

.....

Medical History



Asthma Yes No

Diabetes - Type I Yes No

Diabetes - Type II Yes No

Epilepsy Yes No

Ischaemic Heart Disease Yes No

COPD Yes No

Hypertension Yes No

Stroke Yes No

If yes, please detail below:

Date

Problem

a)

b)

c)

d)

e)

**If female, please give date of last smear
and state if it was normal:**

.....

.....

.....

Allergies

Please list any significant allergies (e.g. medicines) below
.....
.....

Medications



Please list any regularly prescribed medications below
a)
b)
c)
d)

Health

Smoker Yes No
Amount
Past smoker Yes No
Amount
Year stopped

We run smoking clinics to help you quit smoking. Would you be willing to attend
Yes No
If yes, please book an appointment.

Alcohol:

Units per week (1 unit of alcohol = 2 small glass of wine, 1/2 pint of beer or 1 measured spirit):

If you do consume alcohol, please take the time to fill in the chart on the next page.

Measurements:

Height Weight

Last Tetanus

For children, please provide immunisation history:.....
.....
.....

Comments

Is there any other information that you feel is important for us to know, to ensure we can look after you properly?
.....
.....
.....
.....
.....



Exercise:

None Light Moderate Heavy

Health Checks

We invite all new patients to attend a new patient health check with our practice HCA or Nurse when you register with the practice.

Carers

Are you a carer? Yes No
Do you have a carer? Yes No

Alcohol Questionnaire

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times/ monthly	2-3 times/ week	4+ times/ week	
How many unites of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often have you had 6 or more unites if female or 8 or more unites if male on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you score 5 or above you may be at risk of developing alcohol related disease. You may be contacted by a member of staff to discuss this further.

What is your ethnic group?
Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background

A White

Scottish

Other British

Irish

Any other White background

.....

B Mixed

Any Mixed background

.....

C Asian, Asian Scottish, or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

.....

D Black, Black Scottish, or Black British

Caribbean

African

Any other Black Background

.....

E Other ethnic background

.....

Please hand this to the receptionists when you have completed it