St Paul's Clinic
Palmyra Place
Newport
NP20 4EJ
Tel: 01633 266140

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NEW PATIENT QUESTIONNAIRE

This set of questions has been designed to help your new GP get to know you and your medical problems. The information provided will be treated confidentially but, if you are concerned about any of the questions, leave them blank. Your Doctor/Nurse will be pleased to clarify any points. If there are any changed to your circumstances in the future, kindly let us know so that we can update your records.

(Strictly confidential) **Date: / /**

Personal Details:

Mr/Mrs/Ms/Miss/Other:_____

_

First Name ***Middle Name*** ***Surname***

Address:_____

_

_____ Post Code:_____ Date of Birth:_____

Telephone: Home:_____ Mobile:_____ Work:_____

Marital Status: Single/ Married / Divorced / Separated / Widowed /Living with partner

Number of Children:

Ethnic background: (this information is required as certain ethnic groups are prone to particular conditions)

White British		Black African		Chinese	
White other (please specify)		Indian		Mixed (please specify)	
Black Caribbean		Pakistan			

Country of origin _____

Smoking

Never smoked		Trivial – 1 cigarette/day		Moderate 10-19 cigarettes/day		Very heavy 40+ cigarettes/day	
Current non smoker		Light 1-9 cigarettes/day		Heavy 20-39 cigarettes/day			

Alcohol

Teetotal		Light 1-2 units/day		Heavy 7-9 units/day	
Trivial 1 units/day		Moderate 3-6 units/day		Very heavy 9+ units/day	

Exercise

Do you exercise?	Minutes	Times per week
Running		
Swimming		
Walking		
Other (please specify)		

Diet

How would you describe you're diet?

Normal I eat everything Tick if applicable		Other (e.g. Vegitarian/vegan, please give details:

Height: _____ Weight:_____

Allergies: Are you allergic or sensitive to any medicines, food, animals etc? Yes / NO *(please circle)*

If yes, please specific: _____

Current Medial history

Do you suffer or have you suffered from the following:

Heart Attack/Angina		Tuberculosis		Glaucoma			
Disability (Mental/Physical)		Chronic Bronchitis		Arthritis			
High blood Pressure		Diabetes		Migraine			
Stroke		Thyroid disease		Asthma			
Depression/Mental Illness		Epilepsy		Eczema			
Ulcer (Gastric/Duodenal)		Cancer		Hay Fever			
Operations (Surgical)		Hysterectomy		Accident			
Hearing Difficulty		Poor Eyesight		Other Illness			
				None of these			

If **YES** please GIVE DETAILS:

_____

Please list any hospital admissions, operations and accidents with approximate dates:

_____

Are you under the care of a Hospital Specialist? YES/NO (please circle) If YES give details:

_____

List any medication you are currently taking or please submit evidence to the reception:

Family History: (Parents/Grandparents/ Siblings only)

Heart Attack/Angina		Tuberculosis		Glaucoma			
Disability (Mental/Physical)		Chronic Bronchitis		Arthritis			
High blood Pressure		Diabetes		Migraine			
Stroke		Thyroid disease		Asthma			
Depression/Mental Illness		Epilepsy		Eczema			
Ulcer (Gastric/Duodenal)		Cancer		Hay Fever			
Operations (Surgical)		Hysterectomy		Accident			
Hearing Difficulty		Poor Eyesight		Other Illness			
				None of these			

If YES give details:

Do you look after an elderly or disabled relative or friend or somebody with a long term illness? *Please give details*

Details of any other information which you think we might find useful, e.g. housebound, special needs, etc:

Women Only: Date of last smear:

Do you use any form of contraception: YES/ NO (please circle)

If yes, please give details

Have you had any previous abnormal smears: YES / NO

If yes, please give details

Have you had any pregnancies/miscarriages: YES/NO

If yes, please give details

Have you had a hysterectomy: YES/NO

If yes, please give details

Are you aware of any breast problems: YES/NO

If yes, please give details