NEW PATIENT QUESTIONNAIRE

(For Patients aged 16 and above)

Please complete this form and return to the surgery with the GMS1 registration form.
If you have a smartphone or tablet please consider registering to use the NHS App which will give you access to all our available online services. Information is available at:
https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/
Alternatively it is possible to access online services via Patient Access using a PC. Forms are available on our website to register for this service: https://www.carisbrookesurgery.co.uk

Surname: _____ **Forenames**:_____

Title:_____ **Date of Birth**:_____/_____/_____

Address:_____

_____

Postcode:_____ Telephone No. **Home**:_____

Work:_____

CONSENT

By providing your email address and/or mobile number you are giving consent for Carisbrooke Surgery to contact you by text message or email in relation to your healthcare.
We do not pass on any information to third parties without your explicit consent.

Email Address:_____ **Mobile**:_____

Status: Single / Living with Partner / Married / Divorced / Widowed / Other _____

Occupation:_____ Unemployed or Seeking work: Yes / No

Are you currently serving or have previously served in the armed forces? Yes / No

If yes please provide details:_____

Ethnicity: White / Black / Mixed Race / Asian / Arabic / Indian / Caribbean / African /

Chinese / European / British / English / Irish / Scottish / Welsh / Other _____

Language: Please state your main first spoken language:_____

Preferred Language:_____ Religion:_____

Country of Birth:_____ Date first entered UK:_____/_____/_____ (If Applicable)

Next of Kin (Name):_____ Relationship to you:_____

Address:_____ Tel:_____

_____

Number of Children you have:_____

(Women only) Current Pregnancy EDD:_____ (If Applicable)

Are you currently a carer for someone? Yes / No

Other members of your household – please list everyone who lives with you (adults & children):

Name	Date of Birth / Age	Relationship

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Have you had any serious illnesses? Yes / No Details:_____
(e.g. Heart Disease, Angina, Asthma, Stroke, Diabetes, Cancer, Epilepsy, Mental Illness)

Have any of these illnesses affected other members of your immediate family? Yes / No
(Parents / grandparents / brothers / sisters)

If yes, please provide information below. If the relative died from the illness please provide age of death (e.g. Heart Disease, Cancer, Diabetes, etc.)

Relation	Illness	Age at Death

What operations have you had? Please list in date order

Type of Operation	Date

Do you have any medical problems at present? (If none please state none):_____

Please list any allergies that you may have:_____

Please list any tablets, medicines or other treatments you are taking (include those bought from the chemist)_____
_____

Please provide details of your preferred pharmacy for your prescriptions to be sent to:
_____

Please list your most recent immunisations and the date if known:
_____
_____

Do you smoke?
Never Smoked ☐ / Occasional/social smoker ☐ / Ex-Smoker ☐ Approx date_____
Current Smoker ☐ How many each day? _____

Do you drink alcohol?
Yes / No If Yes, how many units each week?_____
Never drunk alcohol ☐ / Drink rarely ☐ / Occasional/Social Drinker ☐

What sort of exercise do you take? E.g. Walking, running, gym etc:_____
_____

Diet- Please describe any special diet you may be on
Vegan ☐ / Vegetarian ☐ / Other (please state)_____
Do you eat fruit? Yes ☐ / No ☐ / Some ☐ _____
Do you eat vegetables? ? Yes ☐ / No ☐ / Some ☐ _____

Thank you for taking the time to complete this form

Your signature_____ Date _____