FAVELL PLUS SURGERY

NEW PATIENT QUESTIONAIRE

PLEASE ANSWER ALL QUESTIONS FROM PAGE 1-3 AS IT MAY TAKE SOME TIME TO OBTAIN YOUR PREVIOUS MEDICAL HISTORY. USE CAPITAL LETTERS FOR ALL QUESTIONS. DO NOT FILL PAGE 4.

Title: ☐Mr ☐ Mrs ☐Ms ☐Miss ☐Dr

Martial Status: ☐Single ☐Married ☐Divorced ☐ Widowed

First Name's.....

Surname .....

Date of Birth .....Country of Birth.....

Address.....

Post Code.....Email Address.....

Tel No Home.....Tel No Mobile .....

Tel No Work..... Other Tel No .....

Occupation .....Main Spoken Language .....

Next of Kin's Name.....

Relationship to you .....

Next of Kin's address .....

Next of Kin's telephone number(s) .....

Do you want to subscribe to online Services ☐ Yes ☐ No, if yes you must have a valid email address to avail this facility. Please write down your email address very clearly in CAPITAL (big) Letters, as your details will be emailed on this email address. Practice is not responsible if you have provided an incorrect email address.

Are you a Veteran: ☐ Yes ☐ No

Are you a Carer for anyone with a serious illness / disability? ☐ Yes ☐ No

If yes – Do you give permission to us to share your information with Northamptonshire Carers ☐ Yes ☐ No

Please list any allergies that you have:

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Please list any operations / illnesses / disabilities:

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Please list all medication that you are currently taking:

Name		Strength	Dose
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Where possible provide the repeat medication slip from your previous GP.

Women only

Have you had a Cervical Smear test done? ☐YES ☐ NO
If yes when was your last Cervical Smear?

Date: ..... Result: .....

ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic Origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origin may help with the early identification of some of these conditions.

Please tick one section from A to E, and then tick which applies to your background.

A	☐ WHITE	☐ BRITISH
		☐ IRISH
		☐ ANY OTHER WHITE BACKGROUND
B	☐ MIXED	☐ WHITE AND BLACK CARIBBEAN
		☐ WHITE AND BLACK AFRICAN
		☐ WHITE AND ASIAN
		☐ ANY OTHER MIXED BACKGROUND
C	☐ ASIAN OR ASIAN BRISTISH	☐ INDIAN
		☐ PAKISTANI
		☐ BANGLADESHI
		☐ ANY OTHER ASIAN BACKGROUND
D	☐ BLACK OR BLACK BRITISH	☐ CARIBBEAN
		☐ AFRICIAN
		☐ ANY OTHER BLACK BACKGROUND
E	☐ CHINESE OR OTHER ETHNIC GROUP	☐ CHINESE
		☐ ANY OTHER PLEASE STATE BELOW

Declined to state ethnic origin ☐
(Please tick the box if you would prefer not to state your ethnic origin)

End of this Questionnaire, please do not write anything on the next Page 4 which is the last page of this form, if you do that you will have to submit another form.

New Patient Health Check

		Y	N	COMMENT
Weight				
Height				
Systolic BP				
Dias BP				
Smoking				
Alcohol				
Diet				
Exercise Grading				
Urine protein				
Urine Glucose				
Urine Blood				
Gen Contra Advice				
Family History				
FH: IHD < 60				
Family member				
FH: IHD > 60				
Family member				
FH: CVA/Stroke				
Family member				
FH: Diabetes				
Family member				
FH: Asthma				
Family member				