THE KILLINGHOLME SURGERY

New Patient Questionnaire

Surname…….. First Name(s)……

Address……..

……..

Post Code…… Ethnic Origin……

Marital Status…… Date of Birth……

Telephone No (home)……. (Mobile)…….

Main Spoken Language…… (If not English) do you speak English Y / N

Next of Kin (name)…… relationship……..

Contact Number…….

Registered with The Killingholme Surgery Y / N

Illnesses or Operations with dates

……
……
……..

What medicines are you taking?

……
……
……..

Have you any allergies? .....

Family History

Which of your blood relatives have suffered with the following?

Heart Attack…….. Cancer……..

High Blood Pressure…… Diabetes…….

Asthma…… Stroke……

Any other illnesses……

Height…….. Weight……..

Do you smoke? Yes / No (please circle) Have you ever smoked? Yes /No (please circle)

If you smoke how much tobacco or cigarettes do you smoke daily? .....

<u>Alcohol –</u> please circle the answer that is right for you

How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times per month 2-3 times per week 4 or more per week

How many units of alcohol do you drink on a typical day when you are drinking?

N/A 1 or 2 3 or 4 5 or 6 7 or 8 10 or more

How often have you had 6 or more units if female and 8 units if male on a single occasion?

Never less than monthly Monthly Weekly Daily or almost daily

<u>Female Patients only</u>

Have you had a hysterectomy? Y / N Date……

When was your last smear test? .....

Do you use contraception? .....

Do you look after or support someone who is ill, frail or disabled? Yes / No

Do you have someone who looks after you? Yes /No

Please give contact details…….

……

Do you have any communication needs? Yes ☐ No ☐

Please give details: ……..
…….

Are we able to share your information with other NHS providers? Yes/No

Can we contact you via text message? Yes/No

Thank you for taking the time to complete this questionnaire.

The information you have given us will be entered onto your notes held at this surgery