

## **FRAMLINGHAM MEDICAL PRACTICE** **NEW PATIENT QUESTIONNAIRE**

Surname:		Previous Name:	
First name(s):		Male	Age:
Date of Birth:		Female	
Place of Birth:		NHS No:	
Address:			
Post Code:		Telephone No:	
Email:		Mobile No:	
Next of kin:		Telephone No:	

<b>Are you a carer for someone:</b>	Yes	No	<b>Is someone a carer for you:</b>	Yes	No
If you answered YES to either of the last two questions - our receptionists will provide you with a Carers Questionnaire.					

Which Ethnic Origin Group do you belong to?	Please Tick	Which Ethnic Origin Group do you belong to?	Please Tick
British White or Mixed British		Pakistani/British	
Irish		Bandladeshi/British	
Other White		Other Asian	
White and Black Caribbean		Caribbean	
White and Black African		African	
White and Asian		Other Black	
Other Mixed		Chinese	
Indian/British		Ethnic group not given – patient refused	

<b>Please advise us of your First Language</b>			
English		Other (which language do you use instead?)	

<b>Do you suffer from any allergies?</b>	YES	NO
Please list them:		

<b>DO YOU SMOKE?</b>	Never?		
	Ex smoker?		If yes, give date you gave up:
	Current smoker?		Would you like help to give up?

How often do you have a drink containing alcohol?		How many drinks containing alcohol do you have on a typical day when you are drinking?		How often do you have six or more drinks on one occasion?	
	√		√		√
Never	0	1 or 2	0	Never	0
Monthly or less	1	3 or 4	1	Less than monthly	1
2-3 times a month	2	5 or 6	2	Monthly	2
2-3 times a week	3	7, 8 or 9	3	Weekly	3
4 or more times a week	4	10 or more	4	Daily or almost daily	4

**PTO**

Please indicate with a tick if you have ever had any of the following:

<b>High Blood Pressure</b>	
<b>Angina</b>	
<b>Heart attack</b>	
<b>Stroke(s)</b>	
<b>Diabetes</b>	
<b>Underactive thyroid (hypothyroidism)</b>	

<b>Asthma</b>	
<b>Chronic bronchitis</b>	
<b>Depression</b>	
<b>Manic Depression</b>	
<b>Schizophrenia</b>	
<b>Epilepsy</b>	

Please list your current medication below:

<b>Name of tablet</b>	<b>Dose</b>	<b>How often do you take it</b>	<b>Reason</b>

**We would appreciate a copy of your repeat prescription list for our records. If you are on regular medication you will need an appointment with our nurse or doctor.**

**Do you take ALL the medicines listed on your repeat slip?**

**If not, which do you no longer take?**

**Do you know what each of your medicines is for and when to take them?**

**Do you ever forget to take your medicines?**

**Do you experience any problems opening the packaging or taking your medicines?**

**Do you take any other medicines including any that you buy over the counter? If so please tell us what they are:**

**Thank you for completing this form, the information will be entered onto our clinical system to help the Doctors and Nurses give you the best treatment/ advice possible and remains completely confidential.**