NEW PATIENT QUESTIONNAIRE

STRICTLY CONFIDENTIAL TO THE NORTH CARDIFF MEDICAL CENTRE

Please fill in both sides of this form accurately, as the information which you provide becomes part of your medical record.

Personal Details **Date…../…../…..**

Surname		Initials		Title	
First Name		Date of Birth			
Address					
Home Telephone		Mobile Telephone			
Work Telephone		E-mail Address			
Occupation					
Are you a recognised Carer?	Yes No	Are they Registered with the Practice?		Yes No	
Please provide their details (name/DOB)					
Are any members of your family registered at the Practice? Please provide their details (name/DOB)					

Ethnic Origin

Please indicate your racial origin, as this is relevant to certain health needs.

□ British or Mixed British	□ Indian	□ Other Asian
□ European	□ Pakistani	□ Other ethnic group
□ Caribbean	□ Japanese	□ I do not wish to give this information
□ African	□ Chinese	

General Statistics

Height		Weight	

Please Turn Over……..

Allergies

Drug Allergies		Non-Drug Allergies	

Access Requirements

Do you have any disabilities which may restrict your access to services? For example: hearing/sight difficulties.	

Smoking

Have you ever smoked?	Yes No	If YES, do you still smoke?	Yes No
How many per day?		If you are an ex-smoker, when did you give up?	

Alcohol

Looking at an average day, how much alcohol do you drink?

□Teetotaller □ 1-2 units a day □7-9 units a day

□Rarely □ 3-6 units a day □ +9 units

1 unit of alcohol is 1/2 pint of beer, 1 glass wine or 1 pub measure of spirits.

Exercise

How much exercise do you take?

□ None □ Light □ Moderate □ Vigorous

Repeat Medication

Are you on any repeat medication?	Yes No If YES please provide your repeat prescription slip if possible