**Gilmore Medical Practice**

New Patient Questionnaire

Welcome to Gilmore medical Practice. In order for us to provide you with the most appropriate care we would be grateful if you would complete and return the attached questionnaire along with the following documents.

1. Photographic ID (passport, ID card or driving licence)
2. Proof of address in your name (i.e. Mortgage/rental agreement, utility bill or bank statement). Failure to produce documentation will delay your registration.

**Please note:** We do not accept registrations from patients moving from a neighbouring practice. We do however continue to register residents newly moved into the area.

**PATIENT DETAILS:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** |  | | | | | **Male:** | | | | **Female:** |
| **Have you been registered with this practice before?** Please tick Yes No | | | | | | | | | | |
| **Name:** | | **Title:**  **(Please State e.g. Mr, Mrs, Miss, Master, MX or Other)** | | | | | **Tele No:** | | |  |
|  | | | | | **Mobile No:** | | |  |
|  | | | | | **Work No:** | | |  |
| **Address:** | |  | | | | | **Postcode:** | | |  |
| **Date of Birth:** | |  | | | | | **Country of**  **Birth** | | |  |
| **Marital Status:** | |  | | | | | **Ethnicity:** | | |  |
| **Are you a student:** Yes No | | | | | | | | | | |
| **Are you a carer:** Yes No  (do you care for a relative or friend other than normal childcare) | | | | | | | | | | |
| **Are you happy to receive appointment text messages from the practice:** Yes No  (only for over 16 year olds) | | | | | | | | | | |
| **Next of Kin:** (who to contact in an Emergency)  Name: ............................................................... Relationship: .....................................................  Telephone Number: ....................................................................................................................... | | | | | | | | | | |
| **Smoking Status**: | | | Current Smoker: (if yes how many a day) | | | | | | | |
| Ex Smoker: | | | | Date Stopped: | | | | Never smoked: | | |
| **For Female Patients Only** | | | | | | | | | | |
| **Date of Last Cervical Smear:**  Date: ................................. | | | | | **Location :** UK  Outside UK | | | | **Result**: Normal  Abnormal | |
| (if outside UK please state where) ....................................................................................................................... | | | | | | | | | | |
| **Alcohol Consumption**  How many units of alcohol do you drink per week?  (one unit = half a pint of beer/lager, one small glass of wine/sherry or one measure of spirits)  None 1-7 8-14 15-21 22-30 +31 | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Gilmore Medical Practice -New Patient Questionnaire** | | | | | |
| **General History** | | | | | |
| Have you ever suffered from any of the following: | | | | | |
| **Angina**  **Asthma**  **COPD**  **Depression** | **Diabetes** |  | | **High Blood Pressure** |  |
| **Epilepsy** |  | | **Learning Disability** |  |
| **Heart Attack** |  | | **Stroke / TIA** |  |
|  |  | |  |  |
| **Any Other Significant illness**  (Please Specify) .....................................................................................................................................  ................................................................................................................................................................. | | | | | |
| **Do you have any allergies to drugs or anything else?**  If so, please specify..................................................................................................................................  .................................................................................................................................................................  ................................................................................................................................................................ | | | | | |
| **Are you on any regular medication (including Contraception)?**  If yes, please tell us the name and dose of medication;-  ............................................................................................................................................................  ............................................................................................................................................................  ............................................................................................................................................................  ............................................................................................................................................................  We would encourage you to make a GP appointment to ensure that regular medications are added to our repeat prescribing system were appropriate. | | | | | |
| **Have you had any Operations?**  If yes, please specify**.....................................................................................................................**  **.....................................................................................................................................................** | | | | | |
| **Family History**  Have any of the following relatives – mother, father, brother or sister had | | | | | |
| **A heart attack**  (age less than 60) | | | **A Stroke** | | |
| **Angina** | | | **High Blood Pressure** | | |
| **Diabetes** | | | **Asthma** | | |
| If yes, please state relationship and give age when they first had the illness diagnosed or any other significant illness not listed. | | | | | |
| **Immunisations**: Please give details of any immunisations you have received and the country you received them in. | | | | | |
| **Blood Pressure**  Guidelines for good practice advise that patients over the age of 40 have their blood pressure checked once every 5 years. If you have not had this done you can make an appointment with the practice nurse to do so. | | | | | |

**NEW PATIENT FORM**

**Welcome to the practice.**

**Please indicate if you need any of the below services?**

|  |  |
| --- | --- |
| 1. Contraception appointment with the Nurse |  |
| 1. Wellbeing / Mental Health appointment with the nurse |  |
| 1. Telephone Medication appointment with our practice   Pharmacists – to discuss your previous repeat medication. |  |
| 1. Chronic disease appointment with the Nurse   (Diabetes, hypertension, heart disease, asthma or COPD) |  |
| 1. Key Information Summary –I consent for the practice to allow the hospital and emergency services access to a summary of my medical conditions/next of kin/or special information about my health needs |  |

Patient Name: …………………………………………………………….. Date of Birth ……………………………………………….



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