Fig Tree Medical Practice - NEW PATIENT QUESTIONNAIRE - STRICTLY CONFIDENTIAL

This information will be recorded on your medical records and will help us to provide your medical care.

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| **Full Name:** | **Previous Surname:** | **Date of birth:** |
| **Full Address:** | Contact telephone numbers:C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngHome:C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngMobile:C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngWork:C:\Users\janet.walker\AppData\Local\Microsoft\Windows\INetCache\IE\LT21049X\phone_PNG48935[1].pngEmergency contact**:****Do you consent to receiving text message reminders?**YES/NO |
| **Name and address of your previous GP:** |
| **Sexual orientation: Which of the following best describes how you think of yourself:**Homosexual StraightGay or Lesbian BisexualIn another way (please state): | **Gender Identity and Trans Status Monitoring*** Woman (including trans women)
* Man (including trans man)
* Non-binary
* In another way (please state):
* Is your gender identity the same as the gender you were given at birth? YES/NO
 |
| **Occupation:** | **Religion:** | **Next of Kin:** | **Marital Status:** |
| **Ethnicity**: | **Preferred spoken language:** | **Do you need an interpreter?**YES / NO |
|  | **If yes, please provide details:** |
| Do you have any current medical conditions? | YES / NO |
| Do you have any allergies? | YES / NO (If yes please list) |
| Are you a Carer for someone? | YES / NO |
| Are you a Foster Carer? | YES / NO |
| Do you have a Carer? | YES/NO (If yes, please provide a contact name andnumber) |
| Are you a Military Service Veteran? | YES / NO |
| **Females Only:**Are you pregnant? YES / NO If yes, when is your due date?How many children do you have? | **Names and date of birth of Children:** |
| When was your last smear test? |  |
| **Do you take any regular medicines?**YES / NO (If yes, please list all medicines and dosage or attach a copy of your repeat prescription)  |
| **Please tick your current smoking status:**Smoker Ex-smoker Never smokedIf you are a smoke – how many do you smoke each day?  |
| **Please answer all 3 questions:****How often do you have a drink containing alcohol?**N/A NEVER MONTHLY OR LESS 2-4 A MONTH 2-3 A WEEK 4+ WEEKLY**How many units do you drink on a typical day when you have a drink?**N/A 1-2 3-4 5-6 7-9 10+**How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?**N/A Never Less than monthly Monthly Weekly Daily or almost daily\\SERVER\Home\manager\Desktop\units 2.png |
| **Additional information:** |
| **If you would like to register for online services, allowing you to make appointments and order your prescriptions online, please provide an email address:****Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Please make an appointment for a New Patient Health Check and please bring a urine sample along with you. Patients over the age of 40 may require a blood test.

The Practice will automatically create a summary care record for you, if you would like to find out more or opt out of this, please let the receptionist know.