YELL HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE

You have now registered with Dr Holloran. As it will be some time before your old records reach us, it would be helpful if you could answer the following questions on your own or your child's health.

NAME: ……
Mr/Miss/Mrs
Marital Status: .....

DATE OF BIRTH .....

TEL NO: ……

MOBILE NO: ……

WORK NO: .....
(if OK to ring you whilst you are at work)

E-MAIL ADDRESS: ……

ADDRESS: ……

……

NEXT OF KIN:……

ADDRESS .....

.....

TEL NO: ……

NEXT OF KIN:……

ADDRESS .....

.....

TEL NO: ……

Please give details of 2 people with at least 1 living at a different address to yourself

Are you a carer:

	Yes	No	Date	Details
Have you suffered from any illnesses in the past? (eg heart disease, , diabetes, hypertension)				
Have you had any operations?				
Do you have any allergies?				

Are you taking any medicines?

Name	Amount per day
1.	
2.	
3.	
4.	

LIFESTYLE FACTORS

Do you smoke? YES/NO If YES, how many per day? .....
Have you smoked in the past? YES/NO If YES, how many per day? .....
When did you stop? ……

How many glasses of wine ……)
spirits ……) do you drink in an average week?
Pints of beer ……)

Do you undertake regular exercise? YES/NO. If YES, please give details and frequency……

……

ADULT IMMUNISATIONS

Have you had any of the following immunisations? If you can remember dates please specify.

IMMUNISATION	YES	NO	DATE
Tetanus			
Diptheria & Tetanus			
Polio			
Hepatitis A			
Hepatitis B			
Typhoid			
Other (please specify)			

FAMILY HISTORY

Is there a family history of any particular health problems (eg diabetes, heart problems, high blood pressure, asthma or any allergies).

……

……

WOMEN ONLY

How many pregnancies have you had? .....

When, if ever, was your last smear test? .....

What was the result? .....

Where did you have this done? .....(GP/HOSPITAL)

FOR CHILDREN 5 YEARS OLD OR UNDER

Has this child had the following immunisations? **(**Please give dates**)**

Diptheria/Pertussis (whooping cough/Tetanus/Polio/H.I.B.	Yes	No	Date	MMR	Yes	No	Date
1st				PRE-SCHOOL BOOSTER			
2nd				BOOSTER MMR			
3rd							

Registration Medical (Adults only) offered: Y/N **Date of appointment** .....

This section to be completed by practice nurse

Height		**BP**		**Diet**	
Weight		**Urinalysis**			

Social History

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

		Read Codes (ALL CHAPTERS)
	White British	.9S10
	White Scottish	.9S13
	White Irish	.9S11
	Any other white background please write in below	.9S12

B Mixed

	White and Black Caribbean	.9i3..
	White and Black African	.9i4..
	White and Asian	.9i5..
	Any other mixed background please write below	.9SB..

C Asian or Asian British

	Indian	.9S6..
	Pakistani	.9S7..
	Bangladeshi	.9S8..
	Any other Asian background please write below	.9SH..

D Black or Black British

	Caribbean	.9S2..
	African	.9S3..
	Any other black background please write below	.9SG..

E Chinese or other ethnic group

	Chinese	.9S9..
	Any other please write below	.9SJ..