PARTICULARS OF NEW PATIENT

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THE INFORMATION ON THIS FORM WILL BE TREATED CONFIDENTIALY AND WILL FORM PART OF YOUR MEDICAL RECORDS. IT IS FOR YOUR DOCTORS USE AND THE INFORMATION ON IT WILL NOT BE GIVEN TO ANY PERSON OR OFFICIAL BODY WITHOUT YOUR PERMISSION.

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HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS PRACTICE? YES/NO

SURNAME……..... FIRST NAME(S)……DATE OF BIRTH……...

MAIDEN/FORMER NAME…….. MARRIED/SINGLE/DIVORCED/CO-HABITING/WIDOWED/CHILD

FULL POSTAL ADDRESS……..

……..

HOME TEL NO……MOBILE NO……

E-MAIL ADDRESS…….

DO YOU WISH TO REGISTER FOR ONLINE PRESCRIPTION REQUESTS? YES/NO

IT IS STANDARD PRACTICE FOR THE OUT OF HOURS SERVICE (NHS 24) TO BE ABLE TO ACCESS ELECTRONICALLY INFORMATION REGARDING ANY ALLERGIES YOU HAVE RECORDED AND CURRENT MEDICATIONS,

IF YOU DO NOT CONSENT TO THIS PLEASE TICK HERE …….

WHAT IS YOUR OCCUPATION? ……

PLEASE GIVE DETAILS OF ANY IMPORTANT ILLNESSES……..

……

ARE YOU ON ANY TABLETS OR MEDICINES? NO/YES IF YES, PLEASE GIVE DETAILS

……
……

ALLERGIES – Are you allergic to any medications? ……..

SMOKING STATUS

SMOKER – HOW MANY PER DAY …….. **Would you like advice on how to STOP SMOKING?** YES/NO

NEVER SMOKED …… EX SMOKER - YEARS SINCE STOPPED ……

DIET

FRUIT & VEG	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
PASTA, PULSES, RICE	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
MEAT, FISH, CHICKEN	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
CAKES, BISCUITS	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
FIZZY DRINKS	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
SWEETS & CHOCOLATE	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY
FAST FOOD	NEVER	1-4 PORTIONS DAY	MORE THAN 5 PORTIONS DAY

Please Turn Over**

EXERCISE (AT LEAST 30 MINUTES)

NEVER LESS THAN ONCE PER WEEK 1-2 TIMES PER WEEK 3-7 TIMES PER WEEK

ALCOHOL QUESTIONNAIRE

DO YOU DRINK ALCOHOL YES NO

F.A.S.T. Screening tool

For the following questions please circle the answer which best applies.
1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

1. How often do you have eight or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of your drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

4. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, but not in the last year Yes, during the last year

****FAMILY HISTORY ****

MI (HEART ATTACK) NO/YES …… WHO and AGE? .....

ANGINA NO/YES …… WHO and AGE? .....

STROKE/CVA NO/YES …… WHO? …….

HIGH CHOLESTEROL NO/YES …… WHO? ……..……

DIABETES NO/YES ……. WHO? ……..……..

HIGH BP NO/YES ……. WHO? ……. .....

OTHER ….. ……

***** NEW PATIENT MEDICAL – TO BE COMPLETED BY NURSE *****

DATE……..

BLOOD PRESSURE …….. HEIGHT ….…… …. cm WEIGHT …… Kg

ANY OTHER INFO
……
……
……

IDENTIFICATION CHECKED _____ FORMS CHECKED _____

RECEPTIONIST INITIALS _____ DATE _____

APPOINTMENT MADE WITH NURSE, ELAINE OR POD – YES_____ NO _____