BILLINGE MEDICAL PRACTICE

New Patient Questionnaire

1. PERSONAL DETAILS

Surname……. First Names(s)……..

Date of Birth……. Place of Birth…….

Please circle
Gender: Male (including trans men) Female (including trans women)

Non-binary In Another Way (Please Specify) _____

Is this the gender you were assigned at birth? Yes / No

Sexual Orientation: Lesbian or Gay / Straight or Heterosexual / Bisexual / Other (please specify)……

Marital Status……

Address……

Home Telephone…… Mobile……

Email Address……

Occupation…… First Language……..

Ethnicity?……

Please state your preferred method of contact (please tick) Home ☐ Mobile ☐ Email ☐
Or any of the above ☐

We want to get better at communicating with our patients. We would like to ensure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know if you have any Special Communication Needs? E.g. BSL interpreter for hearing impairment or large print/braille or you lip read or use a hearing aid or communication tool.

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2. PERSONAL MEDICAL HISTORY

Have you ever suffered from any of the following?

Epilepsy	Yes/No	High Blood Pressure	Yes/No
Glaucoma	Yes/No	Cancer	Yes/No
Where…….			
Diabetes	Yes/No	Heart Attack or Angina	Yes/No
When……..			
Strokes	Yes/No	Asthma	Yes/No
Mental Health Problems	Yes/No		

Please give details of any other serious illness or any time you have stayed in hospital including dates where possible:-

Date	Problem

3. MEDICINES

Are you taking any drugs or medicines? Yes/No

Please tell us the names and dose and how often you take the medicines.

NB You **must** make an appointment to see the Doctor before we issue you with a repeat prescription.

Do you have a nominated pharmacy, if so what is the name _____

WE RESERVE THE RIGHT TO RECONSIDER PRESCRIBING ANY OF YOUR EXISTING MEDICATION AT A FIRST CONSULTATION.

4. ALLERGIES

Are you allergic to any medications? Yes/No

If so, which ones?..... What happens if you take them?.....

5. TOBACCO & ALCOHOL

Are you a current smoker Yes/No If yes how many?..... per day

Are you an ex-smoker Yes/No If yes when did you give up? ……..

How long did you smoke …….. How many did you smoke?..... per day

Do you drink alcohol Yes/No

In a typical week how many pints?..... Glasses of wine……..shorts……

Do you take exercise Yes/No How often?.....

6. FAMILY MEDICAL HISTORY

Has any close first degree relative of yours suffered from any of the following?

Epilepsy	Yes/No	High Blood Pressure	Yes/No
Glaucoma	Yes/No	Cancer	Yes/No
Diabetes	Yes/No	Heart Attack or Angina	Yes/No
Strokes	Yes/No	Asthma	Yes/No

Please give more details…….

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7. ARE YOU A CARER?

Do you look after someone who is ill, frail or disabled? Yes/No

8. VACCINATIONS

Have you had polio and tetanus booster? Yes/No

Polio-Date…… **Tetanus -**Date……..**BCG-**Date……

9. CHILDREN'S IMMUNISATIONS

Please take any immunisation records to surgery when you come for your new patient health check.

Please bring your child's health record (red book) to the first meeting with the nurse.

10. WOMEN, TRANS MEN AND NON-BINARY PEOPLE WITH A CERVIX (OR OTHER PEOPLE WITH A CERVIX

Have you had a cervical smear Yes/No

When was the last one Date……

What was the result…….

11. NEXT OF KIN

Name……. Telephone…….

We would only contact your next of kin in an emergency. We do not divulge confidential information to anyone without your permission.

CONFIDENTIALITY STATEMENT

We hold your patient records in the strictest confidence, regardless of whether they are electronic or on paper. We take all reasonable precautions to prevent unauthorised access to your records, however they are stored. Any information that may identify you is only shared with the practice team, or, if you are referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone else if you give your permission in writing.