

WHAT IS YOUR ETHNIC ORIGIN? Please tick below

Asian Indian		Turkish or Turkish Cypriot	
Asian Pakistani		White British	
Asian Bangladeshi		White Irish	
Asian Other	*	White Other	*
Black Caribbean		Mixed White & Black Caribbean	
Black African		Mixed White & Black African	
Black Other	*	Mixed White & Asian	
Chinese		Mixed Other	*
Greek or Greek Cypriot		Other Ethnic Group	*

* If you ticked 'Other', please specify below:

Main Language Spoken:
 Do you require interpreting services? Yes / No
 What is your religion?

HAVE ANY OF YOUR BLOOD RELATIVES SUFFERED FROM ANY OF THE FOLLOWING? If so please circle below:

BLINDNESS / GLAUCOMA	DIABETES
HIGH BLOOD PRESSURE	ASTHMA
ECZEMA	HAYFEVER
EPILEPSY	HEART ATTACK
RAISED CHOLESTEROL	STROKE
TUBERCULOSIS	CANCER

Thank you for completing this form. The information you give will remain strictly confidential to Members of the Practice Team. It will be entered on a computer database which is registered under the Data Protection Act.

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this form in full and make an appointment to see the Health Care Assistant for a New Patient Medical.

The information from this form and your first medical is essential to help the GP provide you with the very best medical treatment while we wait for your medical records to arrive. Your health information will be entered on your computerised medical record and will be confidential to our Practice Team.

If you need help with filling in this form, please ask at Reception.

TITLE (Mr/Mrs/Miss/Ms/Other)

SURNAME

FORENAME

DATE OF BIRTH MALE / FEMALE

ADDRESS AND

POSTCODE

TELEPHONE HOME

WORK

MOBILE

OCCUPATION

TOWN & COUNTRY OF BIRTH

NEXT OF KIN

Telephone Home

Work

Mobile

ARE YOU CARED FOR BY SOMEONE ELSE?

ARE YOU A CARER? If so, please ask for leaflets about Islington Carer's Forum & explaining your right to DSS entitlements.

Signed: _____ Date: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES/OPERATIONS?

If so, when?

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.....
.....

HAVE YOU EVER SUFFERED FROM THE FOLLOWING?

If so, please circle below:

ASTHMA	DIABETES	ECZEMA
HEART ATTACK	STROKE	HAYFEVER
BLINDNESS / GLAUCOMA	HIGH BLOOD PRESSURE	THYROID PROBLEMS
CANCER	DEPRESSION	EPILEPSY

ARE YOU CURRENTLY TAKING ANY MEDICATION?

IF SO WHAT?

.....
.....

HAVE YOU ANY ALLERGIES TO MEDICINES? / ANYTHING ELSE?

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HAVE YOU HAD A CERVICAL SMEAR?

IF SO, WHEN WAS YOUR LAST SMEAR?

WHAT WAS THE RESULT?

DO YOU USE CONTRACEPTION?

IF SO, WHAT TYPE?

IF YOU ARE TAKING THE ORAL CONTRACEPTIVE PILL,

WHAT IS THE BRAND NAME?

IF YOU SMOKE, HOW MUCH PER DAY?: Cigarettes:

Pipe tobacco: Hand rolled: Cigars:

IF YOU DON'T SMOKE, PLEASE STATE:

DATE OF GIVING UP? NEVER SMOKED

DO YOU DRINK ALCOHOL?

IF SO, HOW MUCH DO YOU DRINK PER DAY?

WINE BEER SPIRITS

WHAT VACCINATIONS HAVE YOU HAD?

Please state dates where possible

POLIO

TETANUS

OTHER

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