Sandhurst Group Practice wants our patients to play a big role in the way the practice runs and the services we provide. To get patients more involved we are creating a Virtual Patient Group (VPG) where we can contact patients via email on current issues. If you would like to join our VPG, please include your email address below:
E-mail : _____

Has the Patient been informed of their new GP? ☐
Has the Patient registered with a Pharmacy for Prescriptions? ☐

NEW PATIENT QUESTIONNAIRE

Your previous medical records may take some time to arrive. By providing the information requested you can greatly assist your Doctor to provide you with an appropriate service for your health needs. Your answers will be kept confidential. Please complete as many questions as you can.

□ Mr □ Mrs □ Miss □ Ms Today's Date: _____

Surname: _____ **All** First Names: _____

Date of Birth: _____ Previous Surname: _____

Home Tel. No: _____ Work/Mobile: _____

Address: _____

_____ Postcode: _____

Email:_____

Do you consent for us to contact you by; Text message □ **Email** □

Next of Kin: _____

Are you: □ Single □ Married □ Separated □ Divorced □ Widow/er

Town & Country of Birth: _____

Ethnicity: □ White/British □ White/Other □ British/Mixed □Black African
□ Black Caribbean □ Black other □ Indian □ Pakistani □ Chinese □ Vietnamese
□ Nepalese □ Other (please specify) _____

Main Language Spoken: _____

If Not English please state if you require an interpreter_____

Have you any other communication requirements_____

If newly arrived from overseas how long do you intend to stay:
_____

If you are returning from the ARMED FORCES OR A VETERAN:

Enlistment date: _____ Leaving date: _____

Are you an Unpaid Carer? □ Yes □ No **Do you have a Carer**? □ Yes □ No

Name of Cared Person _____

Name of your Carer _____

HEALTH HISTORY

Please list any serious illnesses, accidents, operations, disabilities, Long term conditions (Women to include details of all pregnancies) Please use separate sheet as necessary
Date:…… ……
Date:…… ……
Date:…… ……
Date:…… ……
Date:…… ……
Are you waiting to go into hospital for any reason, and if so where?

OCCUPATIONS – Please list with approx. dates. Most recent first.
1. _____ 2. _____ 3. _____

FAMILY HISTORY (blood relatives) Has anyone in your immediate family (Parents, Brothers, Sisters) suffered:

1. Angina / Heart Attack □ Yes □ No If yes as what age _____
   If Yes, what relation to you _____
2. Stroke / Brain Haemorrhage □ Yes □ No If yes at what age_____
   If Yes, what relation to you _____
3. High Blood Pressure □ Yes □ No If yes at what age_____
   If Yes, what relation to you _____
4. Diabetes □ Yes □ No If yes at what age _____
   If Yes, what relation to you _____
5. Cancer □ Yes □ No If yes at what age _____
   If Yes, what relation to you _____

Are there any other major illnesses in your family, e.g. Thyroid problems? _____

DRUGS and MEDICINES
Are you taking any MEDICINES, whether prescribed or purchased from a chemist?
□ Yes □ No If Yes please give details

Name of Drug	How many per day	When started
……	……	……
……	……	……
……	……	……

Are your **ALLERGIC** to any medicine(s)? □ Yes □ No
If yes give details:
Please nominate a Pharmacy for your prescription to be sent electronically to ……..

FOR WOMEN

Are you using a contraceptive? □ Yes □ No

If Yes, what method are you using and for how long?_____

Are you fitted with a coil? □ Yes □ No If yes, when fitted:_____
Are you fitted with a Contraceptive Implant: □ Yes □ No

If yes, when fitted: _____

Have you had a cervical smear? □ Yes □ No Date: _____.

Was this smear taken at your GP's surgery? □ Yes □ No

What was the result if known?
_____

FOR CHILDREN

IMMUNISATIONS Please give dates of those given (or just tick if date unknown):
PRIMARY VACCINE injection contains:
Diphtheria, Tetanus,
Whooping Cough,
HiB, Polio 1st …… 2nd …… 3rd ……

Meningitis C 1st …… 2nd ……
Pneumococcal
(Prevenar) 1st …… 2nd …….. 3rd ……
HiB/MenC
(Menitorix) 1st ……
MMR (measles, mumps & rubella) 1st ……..

and BOOSTER MMR 2nd …….

PRE-SCHOOL BOOSTER 1st ……..
Were these vaccinations given at your GP's surgery? □ Yes □ No

School Attending: _____

Name of persons with parental responsibility: _____

Name of main carer: _____

SMOKING HISTORY - ANYONE AGED 15YRS AND OVER

Have you ever smoked tobacco? □ Yes □ No
If you are a current smoker, please give details of what you smoke each day: _____

If you are an ex-smoker, when did you give up? _____

Do you take any EXERCISE? If so in what form? _____

What is your WEIGHT? _____ What is your HEIGHT? _____

Have you had a TETANUS vaccination in the last 10 years? □ Yes □ No If Yes please give date if known _____

ALCOHOL CONSUMPTION

How much ALCOHOL do you drink **per week?** ….....……units

We are offering a simple screening programme to all new patients to assess drinking patterns. Please ***circle*** *the answer which best applies:*

1 drink/unit = ½pint of beer or 1 small glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?				
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?				
0 No		2 Yes, on one occasion		4 Yes, on more than one occasion
TOTAL SCORE:				

If your score is greater than 3, please book an appointment with your GP to discuss the result.

Is there anything else you would like to tell us about yourself so we may help you better ie Communication needs or a disability _____