LADYWELL MEDICAL CENTRE WEST
Adult NEW PATIENT QUESTIONNAIRE

(Please complete, print off and hand in to the surgery together with Registration Form)

Surname:	**Forenames:**
Address:	Date of Birth:
Postcode:	Telephone Number(s) Home: Work Do you give consent for practice to communicate via text message Y ☐ N ☐ Mobile:
Gender - *Please tick* Male ☐ Female ☐	Occupation:

Marital Status - ***Please tick***

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Co-habiting ☐

Ethnic Origin - ***Please tick***

White British ☐ Black British ☐ White Other ☐ Black Other ☐

Indian ☐ Pakistani ☐ Chinese ☐ Polish ☐

Other Ethic Group please specify _____

Next of Kin

Name:	Relationship:
Address:	Telephone Number(s)
	Home: Work:
	Mobile:

Carer

Are you a Carer YES ☐ NO ☐ If yes, for whom

Are they a patient at this practice?

Disabilities

Do you have any disabilities? YES ☐ NO ☐ If yes, please explain

Allergies

Do you have any allergies? YES ☐ NO ☐ If yes, what are they?

Height and Weight

What is your height?	How much do you weigh?

Please turn over /….

Previous Health: please note any serious illnesses or hospital admissions

Year	Illness/Operation	Hospital

Repeat Medication

Are you on any repeat medication? YES ☐ NO ☐

If you are on any repeat medication please make an appointment with the doctor and bring your medication with you to the appointment

Smoking

Smoking history - *Please tick* Smoker ☐ Ex-smoker ☐ Never smoked ☐	
Ex-smoker – when did you give up?	Smoker – how many do you smoke per day
Would you like information smoking cessation? Yes ☐ No ☐	

Alcohol

Do you drink alcohol? *Please tick* Regularly ☐ Occasional ☐ Are Teetotal ☐

If you do drink alcohol how many units per week?

Family History

Have any close relatives (grandparents, parents, brothers, sisters) had any of the following? Please tick all that apply

Stroke ☐ Heart Attack ☐ Ischaemic Heart Disease ☐

Diabetes ☐ Thyroid Disorder ☐ Osteoporosis ☐

Breast Cancer ☐ Bowel Cancer ☐ Bronchus Cancer ☐

Stomach Cancer ☐ Ovarian Cancer ☐

Any other significant illness – please specify _____