NEW PATIENT QUESTIONNAIRE FOR OVER 16's

Name …… Date of Birth ……..…….

GENDER: ……..

Marital Status

Married	☐	Single	☐
Divorced	☐	Widowed	☐
Seperated	☐		

Occupation ……..

Do you give KIS Consent ? (Key Information Summary) allows important medical information to be shared with healthcare professionals involved in your care, especially in urgent or out-of-hours situations. YES / NO

Next of Kin (pls give details address,: ……..
contact no, relationship): ……..
……..……..……

Is Power of Attorney in Place: YES / NO
If yes, is this active: YES / NO Date activated: …..……..
If yes, please give details: ……..…….

……..……..……

If there a Guardianship order in place: YES / NO
If yese, please give details: …….

……..……..……

Do you have an adults with Incapacity Certificate: YES / NO
If Yes, date completed and how long in place for ……..……..

Are you: A Carer? ☐ Main carer for someone else? ☐ If Yes, Who for? ……..…….

Which ethnic group do you belong to? - ……..……
I do not with to give this information : ☐

IF YOU ARE A WOMAN

Have you had any Miscarriages: YES/NO Stillbirths: YES/NO
Number of Livebirths: ……..……

Are you using any form of contraception at present: YES/NO

If YES - what method? Pill Coil Cap Condom Sterilised
Depoprovera Injection Implants

When was your last Well Woman check up? ……..……...

Have you had a cervical smear? YES/NO If YES, when? ……..……..……

Have you had a mammogram? (age 50 onwards) YES/NO

Have you had a Rubella immunisation? YES/NO

Medical History (If not enough space please detail on separate sheet)

Previous Serious Illnesses Operations and dates

…….. ……

…….. ……

……. ……

ADDITIONAL INFORMATION REQUIRED - PLEASE SEE OVERLEAF

Present regular medication (please list name, strength and how often taken)
If not enough spae please detail on separate sheet

Name	Strength	How often taken
…….	……..	…….
…….	……..	…….
…….	……..	…….

Please continue onto a separate sheet if required

Drug Allergies

……. ……

…….. ……

Family History

Is there anyone in your family who has had (if so at what age)

Heart disease < 60yrs old ☐ **Please give details ……**

Stroke ☐ **Please give details ……**

Cancer ☐ **Please give details …….**

Diabetes ☐ **Please give details ……..…**

Asthma ☐ **Please give details ……**

Smoking Habits

Smoker ☐ **Number of cigarettes/cigars per day ……**

Non-Smoker ☐

Ex-Smoker ☐ **Date Stopped …… Number of cigarettes/cigars per day ……..**

Vapes / E cigarette ☐

Alcohol Intake

Please estimate your alcohol intake per week (1 unit = half pint beer or 1 glass wine or 1 measure spirit)

Number of units per week ……..

How many times per week do you exercise for 20 minutes or more? ……..…..

Current Height ……..……. Current Weight ……

Consent

I understand and agree that it is my responsibilty to keep Bydand Medical Group updated with any changes to my details including name, address, telephone number (mobile & Landline), email address and gender etc. Bydand medical Group can accept no responsibility if details are not updated and out of date information used

By providing the Practice with this information we take this as consent that you agree to being contacted by the Practice using any of the details you have provided including text message & Email.

Signature:……..……..... Date: …….....

PRINT NAME: ……