PATFORD
House Partnership

NEW PATIENT QUESTIONNAIRE

Confidential

Welcome to Patford House Partnership

Please help us by filling in this questionnaire as fully and accurately as you can as it may take some time for your previous medical records to reach us.
A specimen of urine is required which should be brought in with your registration form.

PERSONAL DETAILS

Title (Mr/Mrs/Miss/Ms/Dr/Other: _____
First Name: _____
Surname: _____
Date of Birth: _____
Address:

_____

_____

_____

Telephone number(s): Landline: _____ **Mobile*:** _____
We will text you with appointment and other reminders unless you let us know you do not want these

E-mail address: _____
Marital Status: _____ **Height:** _____ **Weight:** _____
Which ethnic origin do you belong to? Please tick one:
White ☐ Black or Black British ☐ Asian or Asian British ☐ Mixed ☐ Chinese ☐ Other ☐
First Language: _____
Occupation (please give previous occupation if retired)**:** _____
Do you care for a chronically sick or disabled friend/relative? Yes ☐ No ☐
If so, please give their details & relationship to you (if applicable): _____

Do you live alone? Yes ☐ No ☐
Next of Kin name, contact details & relationship to you:

_____

_____

Do you have a disability? Yes ☐ No ☐
Please let us know if there is any way we can help you.

HEALTH

Do any of the following apply to you? Please tick as appropriate:

	Yes, currently	Yes, in the past	No, never
Heart disease	☐	☐	☐
Stomach/duodenal /peptic ulcer	☐	☐	☐
Diabetes Mellitus	☐	☐	☐
Cancer	☐	☐	☐
Asthma	☐	☐	☐
High blood pressure	☐	☐	☐
Stroke	☐	☐	☐
Mental health problems	☐	☐	☐

Have you had any other significant health problems?

Have you had any operations?

LIFESTYLE

Smoking:

Do you smoke? Yes ☐ No ☐ If yes, how many do you smoke per day? _____

Are these Cigarettes ☐ Cigars ☐ Roll your own ☐ Pipe ☐ (please tick any that apply)

If no, have you ever smoked? Yes ☐ No ☐ When did you give up? _____

Smoking is detrimental to your health. If you would like support to give up, please make an appointment with one of our practice nurses.

Exercise:

Do you undertake regular sport or exercise? Yes ☐ No ☐

If yes, please give details: _____

MEDICATION

Please list below any medication you take regularly:

Medication	Strength	How Often

Are there any medications that upset you? _____

Do you have any allergies? _____

Please ensure you have read our Privacy Notice (available on our website and in our waiting rooms) which details how we keep your records safe and how &when we may share your information.

Why Patford House Surgery? (Please tick *all* that apply)

Received a surgery leaflet by post ☐ Picked up surgery leaflet in Calne ☐

Close to home/convenience ☐ Previously registered with the surgery ☐

Recommended by relative/friend ☐ Other (please specify)…….. ☐

Would you be interested in finding out more about our Patient Participation Group?

Yes ☐ No ☐

We aim to register new patients within 5 working days of receipt of the necessary completed forms. If you think you will need to be seen sooner than this, please let the receptionist know.

Please sign: _____ Print: _____ Date: _____