ASHVILLE MEDICAL PRACTICE NEW PATIENT HEALTH QUESTIONNAIRE

Name……..

Date of Birth…….

Address…….

……..

Tel: Number…….
(Please always keep this number up to date with the surgery)

Mobile Number……
(Please always keep this number up to date with the surgery)

Please tick this box if you do NOT wish to receive text messages ☐

Emergency Contact Number……
(Please always keep this number up to date with the surgery)

Email Address……..
Marital Status……

Occupation……

Smoking Status
(Please tick the appropriate box)

Never Smoked ☐ Ex-Smoker ☐ Current Smoker ☐

If you are a smoker and would like to stop smoking please make an appointment at the smoking cessation clinic at the surgery or contact Barnsley stop smoking service on 0800 612 0011

What is your height?.....

What is your weight?……

Have you got any medical problems? Yes ☐ No ☐

If yes what are they?

……

……

Do you take regular medication? Yes ☐ No ☐

If yes what do you take?

……

……

Do you have any allergies? Yes ☐ No ☐

If yes what are you allergic to?

……

Are you a carer or do you have a carer?

Carers are people who care for a family member a friend or another person in need of assistance or support with daily living.

I am a carer ☐

Name of person you care for……

I have a carer ☐

Name of carer……

Do you have difficulty communicating due to a disability? Yes ☐ No ☐
(**A person has a disability if they have a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on the patients' ability to carry out normal day to day activities)**

If you have answered yes do you require:
(please tick the appropriate boxes below)

Information Provided in:

Large Text ☐

Other ☐
(Please state)

……

Communication Support By:

British Sign Language ☐
Interpreter ☐
Deaf Blind Manual Interpreter ☐

(Please state)

……

Ethnic Origin & Nationality

We are required by the government to record the ethnic origin of all our patients who register at the practice. The information is added to your record, however does not affect your treatment received at the practice.

Please tick the relevant box below:

1. White

British ☐
Irish ☐
Scottish ☐
Welsh ☐
Other White Background ☐
(Please State Below)

……..

2. Asian – Asian Scottish, Asian English, Asian Welsh or other Asian British

Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Other Asian Background ☐
(Please State Below)

……

3. Mixed

Any Mixed Background ☐

4. Black – Black Scottish, Black English, Black Welsh or Other Black British

Caribbean ☐
African ☐
Other Black Background ☐
(Please State Below)

……..

5. What is your main spoken language?

English is my 1st language Yes

English is my 2nd language Yes

6. Next of Kin

What is the name of your next of kin? …….. (Please print)

What relation is your next of kin? ……

Next of kin contact telephone number……