

# Weavers Medical - New Patient Questionnaire

## You must bring this completed form to your Registration Appointment

Mr/Mrs/Miss(please circle) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male Female (please circle)

### Address

House name/number \_\_\_\_\_

Street \_\_\_\_\_

Locality \_\_\_\_\_

Town \_\_\_\_\_

Post Code \_\_\_\_\_

How long have you lived in the UK? \_\_\_\_\_

Are you planning to leave the UK within the next 6 months? \_\_\_\_\_

If yes, is this for more than 3 months? \_\_\_\_\_

### Contact Numbers

Telephone No (Day) \_\_\_\_\_

Telephone No \_\_\_\_\_

(Home/Evening)

Mobile No \_\_\_\_\_

### Ethnic Origin

British or mixed British

Irish

Other White background

White and Black Caribbean

White and Black African

White and Asian

Other Mixed background

Indian or British Indian

Pakistani or British Pakistani

Bangladeshi or British Bangladeshi

Other Asian background

Caribbean

African

Other Black background

Chinese

Other Please State \_\_\_\_\_

Do you speak/understand English? Yes / No If No What Language Do you speak? \_\_\_\_\_

Where were you born? Country \_\_\_\_\_ County \_\_\_\_\_ Town \_\_\_\_\_

If NO, do you require an interpreter? \_\_\_\_\_

SMOKING RECORD

Never Smoked   
Current Smoker   
Daily Amount \_\_\_\_\_  
Ex Smoker

ALCOHOL CONSUMPTION

Teetotaler   
Drinks rarely   
Light Drinker   
Moderate Drinker   
Heavy Drinker   
Stopped Drinking

No. of units per week \_\_\_\_\_

NEXT OF KIN

Next of Kin:  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Post Code \_\_\_\_\_  
Day time Tel No \_\_\_\_\_

DISABILITIES

Are you registered disabled? Y / N  
Please state your disability \_\_\_\_\_

ALLERGIES

Are you allergic or sensitive to any medicines, food, Animals, etc?  
\_\_\_\_\_

EXERCISE GRADING

Impossible   
Inactive   
Light   
Heavy

HEIGHT & WEIGHT

Height \_\_\_\_\_  
Weight \_\_\_\_\_  
Waist Measurement \_\_\_\_\_

HEALTH DETAILS

Are you currently receiving treatment for any of the following?

DISEASE AREA	YES	MEDICATION	HOSPITAL FOLLOW UP	YR OF ONSET	FAMILY HISTORY
ATRIAL FIBRILLATION					
ASTHMA					
CANCER					
COPD (Chronic Obstructive Pulmonary Disease)					
DEMENTIA					
DIABETES					
EPILEPSY					
HEART DISEASE					
HEART FAILURE					
HYPERTENSION					
KIDNEY DISEASE					
LEARNING DISABILITIES					
MENTAL ILL HEALTH					
STROKE					
THYROID PROBLEMS					
KIDNEY DISEASE					

Please indicate any other problems for which you receive monthly prescriptions.  
**Attach copy of current order slip** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any other serious medical illnesses, accidents or operations and year of onset

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*For Office Use only*

<b><i>Proof of identity checked</i></b>	<b>Tick document checked</b>
Passport	
Driving Licence	
Birth Certificate	
Other please state	

<b><i>Proof of Address checked</i></b>	<b><i>Tick document checked</i></b>
Utility Bill	
Letter from Res Home confirming address	
Letter from landlord confirming address	
Other please state	

<b><i>Proof of eligibility status if necessary</i></b>	<b>Tick document checked</b>
Visa	
Residence permit	
Work permit	
Other please state	

Staff member name \_\_\_\_\_

Date \_\_\_\_\_