Partners Dr A S Jheeta Dr M D M Welton Dr H H E Van der Linden Dr K Coleclough Dr Jan Welton (G.P.)	**Trent Vale Medical Practice New Patient Questionnaire**	876 London Road Trent Vale Stoke-on-Trent ST4 5NX Tel: 01782 746898 Fax: 01782 745067 www.trentvalemedicalpractice.co.uk

Please complete all parts of this form this will help us to deliver the best quality health care to you. We cannot register patients with incomplete information.

PERSONAL DETAILS	
Title: Miss/Ms/Mrs/Mr/Dr Full Name:	Date of Birth: Do you look after someone? Yes ☐ No ☐ (Do you look after a relative/friend/neighbour) Does someone look after you? Yes ☐ No ☐
Full Address: Postcode:	Home Telephone No: Mobile No: Work Telephone No: E-Mail address:
Place and country of birth:	First language spoken:
Ethnicity: British / Mixed British / Irish / White & Black Caribbean / White & Black Asian / White & Black African / Indian or British Indian / Pakistani or British Pakistani / Caribbean / African / Chinese / Other White Background / Other Mixed Background / Other Black Background / Other ***(please circle which applies).***	

PREVIOUS G.P. DETAILS	
Name and address of previous G.P:	Have you registered at this Practice in the past? Yes/No

MEDICAL HISTORY
Do you have? ……..

	Have now	**Had in the past, please indicate when**
Heart disease or Heart Attack		
Asthma		
High Blood Pressure		
Diabetes		
Stroke or TIA		
Epilepsy		
Underactive Thyroid		
Chronic Pulmonary Disease/COPD		
Mental Health Problems *(please indicate what kind e.g. anxiety, depression, schizophrenia, alcoholism, drug addiction etc)*		
Cancer *(please state which kind and when diagnosed)*		

Please list any other health problems you have below, including any operations and dates if known.

MEDICATIONS

Please list any medications you are taking below including contraceptives. Alternatively, if you have a repeat medication slip from your previous G.P. we can take a photocopy of this.

Medication Name	Dose of Tablet	How many a day

FAMILY HISTORY – Please circle if any family member (grandparents/parents/siblings) have suffer(ed) from the following:

Heart Attack / Angina / Raised Blood Pressure / Raised Cholesterol / Diabetes / Asthma / Stroke / Breast Cancer / Ovarian Cancer / Blood Clots (DVT or Pulmonary Embolus)

LIFESTYLE

Smoking Status – please tick which statement applies to you:-

Current Smoker ☐ (please state quantity per day) ………………..

Stopped Smoking ☐ (please state quantity per day) .... Never Smoked ☐

PLEASE NOTE – SMOKING IS BAD FOR YOUR HEALTH. PLEASE ASK AT RECEPTION FOR SMOKING CESSATION INFORMATION TO ASSIST YOU TO GIVE UP.

Alcohol

What is your average weekly consumption of alcohol?

Wine……………..units Beer…………..units Spirits…………...units

How often do you have a drink containing alcohol? Please tick which statement applies to you:-

Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐

How many standard drinks containing alcohol do you have on a typical day? Please tick which statement applies to you:-

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐

How often do you have six or more drinks on one occasion? Please tick which statement applies to you:-

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

FOR INFORMATION ON THE RECOMMENDED SAFE LIMITS OF ALCOHOL DRINKING PLEASE ASK AT RECEPTION FOR A LEAFLET. IF YOU FEEL YOU ARE DRINKING ABOVE SAFE LIMITS AND ARE FINDING IT DIFFICULT TO CUT DOWN PLEASE MAKE AN APPOINTMENT WITH A DOCTOR OR PRACTICE NURSE.

Exercise

PLEASE TELL US THE TYPE AND AMOUNT OF PHYSICAL ACTIVITY INVOLVED IN YOUR WORK.
Please tick one box only

I am not in employment (e.g. retired, retired for health reasons, unemployed, full time carer) ☐

I spend most of my time at work sitting (such as in an office) ☐

I spend most of my time at work standing or walking. However my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder) ☐

My work involves definite physical effort including handling of heavy objects and use of tools (eg plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery worker) ☐

My work involves vigorous physical exercise activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector etc) ☐

DURING THE LAST WEEK HOW MANY HOURS DID YOU SPEND ON EACH OF THE FOLLOWING ACTIVITIES? **Please answer whether you are in employment or not**

Physical exercise such as swimming, jogging, aerobics, football, tennis, gym, workout, etc

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Cycling, including cycling to work and during leisure time

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Walking, including walking to work, shopping for pleasure etc

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Housework/Childcare

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Gardening/DIY

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

HOW WOULD YOU DESCRIBE YOUR USUAL WALKING PACE? **Please mark one box only.**

Slow pace ☐ Steady average pace ☐ Brisk pace ☐ Fast pace ☐

FOR INFORMATION ON HOW PHYSICAL ACTIVITY CAN IMPROVE YOUR HEALTH PLEASE ASK AT RECEPTION FOR A LEAFLET.

Diet

Please tick which statement applies to you:-
Vegetarian ☐ Vegan ☐ Weight reducing diet ☐ Low fat diet ☐ Low salt diet ☐ Milk free diet ☐

Egg free diet ☐ High fibre diet ☐ Other …………………………………..

FOR INFORMATION ON HOW A HEALTHY DIET CAN HELP PREVENT OR REDUCE THE SEVERITY OF DISEASES SUCH AS HEART DISEASE, STROKE OR DIABETES, AND HOW TO COMBAT OBESITY AND HELP WITH WEIGHT LOSS PLEASE ASK AT RECEPTION FOR A LEAFLET.

ALLERGIES Please list below any allergies you have	
Name of allergen/medication	**What happened (rash/breathlessness etc)**

Immunisations **Please list immunisations you have received below:**	
Type of Immunisation	**Date**
Tetanus	
Diphtheria	
Polio	
Whooping Cough/Pertussis	
MMR	
Meningococcal C	
HiB	
BCG/Tuberculosis	
Travel Vaccinations, please state which	

FOR OVER 65s ONLY	
How many falls have you had in the last twelve months?	

Many thanks for taking the time to complete this questionnaire. Please ensure that you have answered ALL the questions before handing it to the Receptionist. Please ask for a copy of our Patient Information Leaflet for further information about the services we offer here at Trent Vale Medical Practice.

Signed ……………………………………………… Dated …………………………………

FOR WOMEN ONLY

If you are using contraception please list it below:-

Type of contraception	How long used	How much do you have left?

If you are taking the pill please state if you have ever had any of the following:-

Migraine	Yes/No	Breast Cancer	Yes/No
Blood Clots	Yes/No	Liver Disease	Yes/No
Family history of breast cancer	Yes/No	Family history of blood clots	Yes/No

<u>Long-acting Reversible Contraception</u> - Please ask for a leaflet or see the nurse if you would like to consider any of the following forms of contraception as an alternative to regular pill taking:-

1. **Intra-uterine system or coil (Mirena)**
2. **Depot injection contraceptive**
3. **Implant contraceptive**

If you are using the coil as contraception please state:-

Date inserted: Date of last coil check up ……………………………………..

Please state the date of your last cervical smear:	
Have you ever been pregnant?	Yes / No
If yes please state the number of pregnancies.	