GROVE HOUSE SURGERY NEW PATIENT QUESTIONNAIRE

Please complete the following questionnaire. The answers given will be stored in your confidential record.

FIRST NAME(S)	SURNAME	MALE/FEMALE	DATE OF BIRTH

ADDRESS: POSTCODE:	HOME TEL: MOBILE: WORK: E-MAIL: CONSENT TO LEAVE TELEPHONE/TEXT MESSAGE : YES / NO

NEXT OF KIN:	RELATIONSHIP: CONTACT DETAILS:

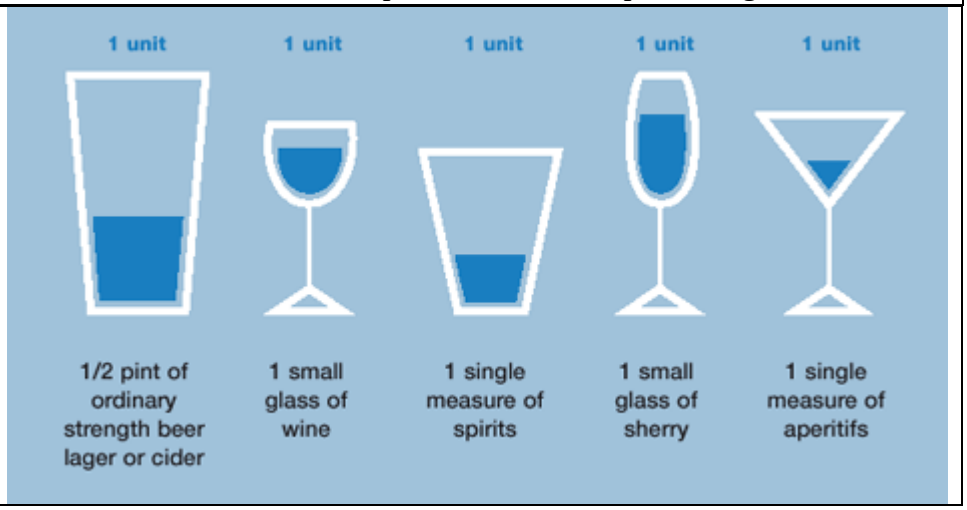
ETHNIC GROUP: Please Circle your group	White		White British
	Other white (please state)		
	Black- Caribbean		Black African
	Black other (please state)		
	Indian	Pakistani	Bangladeshi
	Chinese	Vietnamese	Other (please state)

MAIN SPOKEN LANGUAGE:	
DO YOU NEED AN INTERPRETER	YES/NO

OCCUPATION:

DO YOU SMOKE	YES/NO
IF NO- DID YOU EVER SMOKE	YES/NO
IF YES – HOW MANY	Cigarettes oz
IF YOU HAVE STOPPED - WHEN	

If you want help and support to quit smoking there is a comprehensive NHS FREE SMOKING HELPLINE Tel: 0800 022 4 332 or visit www.smokefree.nhs.uk or ask at reception about our stop smoking clinics.

HOW MUCH ALCOHOL DO YOU DRINK IN A DAY OR A WEEK	

Please complete over the page

HAS ANYONE IN **YOUR FAMILY** EVER SUFFERED FROM:

DIABETES	YES/NO	Family Member/Age at Diagnosis
HEART DISEASE	YES/NO	Family Member/Age at Diagnosis
STROKE	YES/NO	Family Member/Age at Diagnosis
HIGH BLOOD PRESSURE	YES/NO	Family Member/Age at Diagnosis
ASTHMA	YES/NO	Family Member
CANCER	YES/NO	Family Member/Age at Diagnosis/Type

DO YOU HAVE ANY ALLERGIES	

ARE YOU A CARER	Name: Relationship: Contact details:
DO YOU HAVE A CARER	Name: Relationship Contact details:
Are you permanently housebound?	

DO YOU SUFFER FROM:

HIGH BLOOD PRESSURE	YES/NO
ANGINA	YES/NO
HEART DISEASE	YES/NO
STROKE	YES/NO
EPILEPSY/FITS	YES/NO
DIABETES	YES/NO
THYROID PROBLEMS	YES/NO
CANCER	YES/NO
COPD/EMPHYSEMA	YES/NO
ASTHMA	YES/NO
DEPRESSION	YES/NO
KIDNEY PROBLEMS	YES/NO
OTHER (Please specify)	YES/NO

WHAT IS YOUR MOST RECENT WEIGHT:	HEIGHT:

DO YOU EXERCISE	How often
DO YOU HAVE A SPECIAL DIET	eg. Low fat, vegetarian

WHICH MEDICINES ARE YOU CURRENTLY TAKING:

If you would like an appointment to see your GP please tick the box ☐

Signed……Date……

THANK YOU