

# Hedge End Medical Centre New Patient Questionnaire

**Confidential**

## Basic Registration Information

Please Print/Mark clearly

<b>Present Surname:</b>
<b>Previous Surname:</b>
<b>Fornames</b> (underline name by which usually known)
<b>Date of Birth:</b>
<b>Place of Birth:</b>
<b>Address:</b>
<b>Postcode</b>
<b>Telephone no:</b> Home: Work: Mobile:
<b>Occupation:</b>
<b>Name and Address of your previous doctor</b>
<b>Contact in case of an emergency/Next of Kin</b>
<b>Name:</b>
<b>Address:</b>
<b>Tel No:</b>
<b>Relationship to you:</b>
<b>Are you a Carer?</b> Yes                  No <b>If yes:</b> <b>Who do you care for?</b> ..... <b>Do they live with you?</b> Yes                  No <b>Their Age:</b> Male/Female  <b>Or</b> <b>Are you cared for?</b> Yes                  No <b>If yes:</b> <b>By a relative or friend, etc:</b>

<b>Ethnicity:</b> (Please circle appropriate)	
This information can help us plan to meet the needs of the community and ensure that everyone has equal access to the health care we provide. The classification is entirely voluntary but will help us to provide a better service.	
A White British	J Pakistani
B White Irish	K Bangladeshi
C Any other White background	L Any other Asian background
D White and Black Caribbean	M Caribbean
E White and Black African	N African
F White and Asian	P Any other Black background
G Any other mixed background	R Chinese
H Indian	S Any other ethnic Group

## Medical History

Please list below any pregnancies, major illnesses, accidents, or operations. DO NOT include colds, sore throats, flu etc unless they recur persistently.		
Year	Condition/Operation	Hospital (if applicable)

## Medical History Continued

Are you taking or using any medication at present?		
Type	Dosage	
Are you now under hospital treatment or on the waiting list for any surgical procedure? (please circle appropriate)		
Yes                      No		
*Please give details:		
Has anyone in your close family ever had cancer?		
Relationship To you	Type of Cancer	Age at Onset
Do you suffer from any Recurring condition?		Is there a family history of these?
	Your age at Onset	Relationship to you      Their age at onset
Asthma	.....	.....
Eczema	.....	.....
Hay Fever	.....	.....
Bronchitis	.....	.....
Fits	.....	.....
Mental Depression	.....	.....
Other Psychiatric Problems	.....	.....
Diabetes	.....	.....
High blood pressure	.....	.....
Angina/Heart Attack	.....	.....
High Cholesterol	.....	.....
Glaucoma	.....	.....
Stroke	.....	.....
Your height                      .....ft.....ins		
Your current weight            .....st.....lbs		

Have you any major handicap, disability, social problem, or other matter you would like your doctor to know about?			
Have you been immunised against:			
	Year		Year
Diphtheria	.....	Meningitis C	.....
Tetanus	.....	Other	.....
BCG	.....	* Please give details:	
Polio	.....		
Rubella (German measles)	.....		
Are you allergic or sensitive to anything such as penicillin, aspirin, plaster, etc.			
Allergy		What does it do to you?	
Do you smoke?		If non-smoker, did you ever smoke?	
Yes                      No		Yes                      No	
*Please circle appropriate		*Please circle appropriate	
no. per day?		no. per day?	Year stopped
Cigarettes	.....	.....	.....
Cigars/Cigarillos	.....	.....	.....
Pipe	.....	.....	.....
Do you drink alcohol?		Yes                      No	
*Please circle appropriate			
If yes, what is your average weekly consumption? One unit = ½ pt. beer, or 1 glass wine, or 1 measure spirit .....Units			
Do you exercise? *Please circle appropriate			
Regular vigorous exercise		No regular exercise but an active lifestyle	
Moderate exercise		Cannot exercise	
Light exercise		Inadequate exercise	
Is there anything the doctor should know about your diet?			