SPA MEDICAL PRACTICE - NEW PATIENT QUESTIONNAIRE

Surname:	**Mr/Mrs/Ms**	**DOB**
Forname(s)	**NHS NO.**	
Address:	**Tel.No. Home** **Mobile** **Work**	

Other members of the household, names and relationship

What is your ethnic group?			
White British or Mixed British	☐	Asian/British Bangladeshi	☐
White Irish	☐	Asian Other	☐
White Other	☐	Black Caribbean	☐
Mixed White/Black Caribbean	☐	Black African	☐
Mixed White/Black African	☐	Black Other	☐
Mixed White/Asian	☐	Chinese	☐
Mixed Other	☐	Other (please specify below)	☐
Asian/British Indian	☐		
Asian/British Pakistani	☐		
Which country do you come from?	**What is your first Language?**		

Are you a carer? Yes/No *if yes please complete the yellow card in reception*
Are you cared for? Yes/No **Are you Housebound? Yes/No**
Name of carer: **Relationship:** **Tel. No.**

Occupation:	**Previously registered with this practice Yes/No**
Major Illnesses: **1.** **2.** **3.** **4.**	**Prescribed Medications(or attach a list)** **1.** **2.** **3.** **4.**

List any Allergies:

Have you had your Blood pressure checked in the last 5 years Yes/No

Last BP Reading	**Height**	**Weight**

Are you a Smoker ☐ **If yes How Many?** ***If yes you are advised to STOP***
Would you like smoking cessation advice ☐ **Never Smoked** ☐ **Ex-Smoker** ☐

How often do you have a drink that contains Alcohol? Never☐ Monthly or less☐
2-4 times a month☐ 2-3 times per week ☐ 4+times per week☐
How many standard alcoholic drinks do you have on a typical day when you are drinking?
1-2☐ 3-4☐ 5-6☐ 7-8☐ 10+☐
How often do you have 6 or more standard drinks on one occasion?
Never☐ Less than monthly☐ Monthly☐ Weekly ☐ Daily or almost daily☐
PLEASE NOTE: Dependant on your score you may be contacted by an advisor – Permission to contact by phone Yes ☐ **No** ☐

Would you like your prescriptions to be collected by the chemist? **Yes by the Chemist** ☐ **No collect myself** ☐	**Please tick a chemist of your choice.** **Boots** ☐ **Droitwich Pharmacy** ☐ **St Mary's** ☐ **Moss** ☐ **Other please specify**

Do you have your medication supplied in a 28 day dosette or nomad box? Yes☐ **No**☐

Family History of Cancer, Heart Disease, Diabetes, Hypertension,Asthma **1** **2.** **3.** **Other:**	**Father**☐**Mother**☐**Brother**☐**Sister**☐ **Father**☐**Mother**☐**Brother**☐**Sister**☐ **Father**☐**Mother**☐**Brother**☐**Sister**☐
Date:	**Signature**