GRANGE MEDICAL PRACTICE

PATIENT QUESTIONNAIRE

Welcome to the Grange Medical Practice. Please complete this questionnaire as fully as possible. All the information you provide is strictly confidential and will become a part of your medical record	
Title (MR MRS MISS MS)	Marital Status: (MARRIED DIVORCED SINGLE)
Surname:	
First Name	
Date of Birth	Male/ Female
Address:	
Postcode:	Occupation:
Tel: Home and Emergency contact	
Tel:Mobile	
Tel:Work	
e-mail address	
First Language	
Fluent in English YES NO	
Interpreter required? YES NO	
Do you have someone who looks after your daily needs as a carer? YES NO	
Name and contact details of carer	
Do you look after the daily needs of someone as a carer? YES NO	
Name and contact details of the person you care for	

Ethnic origin

African		White British	
Bangladeshi		Other mixed background	
British or Mixed British		Other white background	
Caribbean		Pakistani or British Pakistani	
Chinese		Mixed white and Asian	
Irish		Mixed white and black African	
Indian or British Indian		Mixed white and Caribbean	
Other Asian Background		Other	
European : State Country		I do not want to give my ethnic origin	

Language

Do you speak fluent English?	
What is your first language?	
Do you require an interpreter?	State Country Required :

Do you have a disability we should be aware of? Yes/No

Your medical history

Have you or any member of your immediate family (Mother, Father, Sister, Brother, Child) ever suffered any of the following

Condition	YOU	Which family member?
Stroke		
Raised Blood Pressure		
Heart Disease		
Diabetes		
Asthma other respiratory problem		
Mental health problem		
Thyroid problem		
Epilepsy		
Cancer		

Please list any serious illnesses or operations (date if known)

Serious illnesses	
Operations	

Please give the following information

Height	
Weight	
Do you/Have you ever smoked? If yes how many a day?	
If you have given up please give a date	
Would you like advice to give up?	
Do you drink alcohol, if yes how many units a week?	
Do you take regular exercise?	

Please list any allergies you have

Are you taking regular medication? (please state) Do you have a repeat prescription slip?

Please give this to the receptionist so we can re-order

When did you last have a smear?	
Have you had a hysterectomy?	
Are you taking the contraceptive pill?	
Are you using any other method of contraception?	

When was your last Tetanus injection?

New patient check

All patients over 50 are invited to attend the practice for a health check this will involve height, weight blood pressure, smoking cessation advice and the opportunity to discuss any health concerns you may have.

Please make an appointment for a new patient check with the practice Health Care Assistant

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FOR OFFICE USE ONLY

Address Verified: YES / NO

Staff Member: _____
Date: _____