WYE SURGERY

New Patient Medical Questionnaire p1

Please complete both pages of this questionnaire & return to Wye Surgery with your GMS1 Form.

Personal Details

Surname…… Date of Birth……..

Forenames……

Name of Carer & Relationship (if you have one) ……

*Sex M / F Marital Status……

Address…… Previous GP……

…… Previous GP Address ……

Tel No: ….. …… Tel No……

Mob No…… e-mail address……

First Language ……

Do you give consent for us to contact you on your mobile number Y/N
Do you give consent for us to contact you on your email address Y/N
It is your responsibility to inform us of any change in mobile number or email address.

Next of Kin details

Name…… Relationship……

Address……

…… Telephone number……

Ethnic Origin: Please TICK the relevant box.

☐ British White	☐ Irish White	☐ Other White
☐ White & Black Caribbean	☐ Black Caribbean	☐ White & Black African
☐ Black African	☐ White & Asian	☐ Other Asian
☐ Indian	☐ Chinese	☐ Pakistani
☐ Bangladeshi	☐ Other Black background	☐ Do not wish to declare

Medical History

Have you suffered from any of the following problems? If **YES**, please **TICK** the relevant box and give details below.

☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Asthma
☐ Mental Illness	☐ Tuberculosis	☐ Anxiety/Depression/Stress	☐ Mental Illness
☐ Any operations	☐ Any hospital admissions	☐ Learning Difficulties	

Details – please describe problems, when they occurred, treatment received and whether they still exist

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Do you have any other health problems **NOT** mentioned above? If **YES**, please give details

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continued over

WYE SURGERY

New Patient Medical Questionnaire p2

Are you taking any medicine, pills or any other form of treatment at the moment?

If so what.....

Family History

Has anyone in your immediate family suffered from any of the following? If YES, please TICK and give details

- ☐ Heart Disease.....
- ☐ Diabetes.....
- ☐ Stroke.....
- ☐ Glaucoma.....
- ☐ High Blood Pressure.....
- ☐ Cancer (Colon/Bowel) Age of Onset.....
- ☐ Cancer (Other).....
- ☐ High Cholesterol.....
- ☐ Other Serious Diseases .....
- ☐ Other Information

Health Screening

What is your Height?..... What is your Weight?.....

Do you Smoke? YES/NO (amount per day)..... Have you ever smoked ?.....

Are you allergic to any medication? YES/NO (details).....

Do you drink Alcohol? YES/NO .....

How often do you have a drink containing alcohol? (Please circle)

Never (0) Monthly (1) 2-4 times (2) Per month 2- 3 times (3) Per week 4+ times per week (4)

How many units of alcohol do you drink on a typical day when you are drinking? (Please circle)

1-2 (0) 3-4 (1) 5-6 (2) 7-8 (3) 10+ (4)

How often have you had 6 or more units if you are female or 8 or more units if male, on a single occasion in the last year?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or Almost daily (4)

Total Score = ☐

Is there anything else that may be of help to us?.....

Signed..... Date.....

For Wye Surgery use only

Entered onto computer by .... Date.....