


CLIFTON MEDICAL CENTRE

New Patient Questionnaire

Welcome to Clifton Medical Centre.

To register with this Practice, please complete this questionnaire as fully as possible. The questions have been designed to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us. The information you give will help us to provide you with good medical care.

PERSONAL DETAILS						
Title	Mrs/Miss/Ms/Mr	Have you been registered here before?		Yes	No	
Surname		Previous Name		Male	Female	
Forename(s)		Address				
Date of Birth		Email Address				
NHS number						
Home Tel. No.		Postcode				
Mobile Tel. No.		Email				
Work Tel. No.		Occupation				
Next of kin		Relationship				
Contact No		Address				
Status	Single	Married	Separated	Divorced	Widowed	Cohabiting
HEALTH DETAILS						
Height		m	Weight		kg	
<p>Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments. Your answers will remain confidential so please be honest. Use the guide below to decide how many units you drink a week.</p>						
			Do you drink any alcohol?		Yes	No
			How many units / week?			
Drugs						
			Yes		No	
Are you a smoker?	Yes	No	How many a day?			
Would you like support and/or information on giving up?					Yes	No
Stopped smoking?	Yes	No	When?			
Never smoked?	Yes	No				

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Medical History		
Do you have, or have you had, any serious health problems (including operations) / long term conditions?		
	Details	Date (if known)
Asthma		
Cancer		
COPD		
Chronic Kidney Disease		
Diabetes		
Epilepsy		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Osteoporosis		
Stroke		
Mental Health Problems		
Thyroid problems		
Circulation problems		
Rheumatoid Arthritis		
Other serious illnesses		
Any operations		
Any known allergies		
Details of the reaction		

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Repeat medication		
Are you on any repeated medication?	Yes	No
If "Yes", do you have a repeat prescription slip from your previous GP?	Yes	No
If "Yes", please hand it in at Reception. If "No" then list below any current medication you are taking and make sure you show Reception all your medication in its original packaging and labelling. We may need to contact your previous GP surgery to confirm your medication.		
Name of drug	Frequency (how often taking it)	Reason for using drug

Family Medical History			
Have you or any of your immediate relatives (brothers/sisters/parents) had any of the following			
Tick box if applicable and give details if you can.			
	Details	Relationship	Date (if known)
Heart attack or angina before age 60			
Heart attack or angina over age 60			
Asthma			
Diabetes			
Stroke			
Cancer			
Any inherited diseases			

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Hospital Care (The doctor may discuss with you the possibility of transferring your care to a local hospital)			
Are you currently under hospital care?	Yes	No	If "Yes" then complete details below
Hospital Name	Name of Consultant		Nature of problem

Do you consider yourself to have a disability?	Yes	No
Physical Impairment		
Sensory Impairment		
Learning Disability/Difficulty		
Mental Health Condition		
Other (please state)		
Are you a carer?		
Is someone a carer for you?		

FEMALES ONLY			
Date of last cervical smear?		Are you pregnant?	Yes No
Have you had a hysterectomy?	Yes No		

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Children Only		
Please provide details of all vaccinations		
When vaccines scheduled	Vaccines due	Date Given
Two Months Old	DTaP/IPV/Hib	
	Pneumococcal	
	Meningitis B	
	Rotavirus	
Three Months Old	DTaP/IPV/Hib	
	Meningitis C	
	Rotavirus	
Four Months Old	DTaP/IPV/Hib	
	Pneumococcal	
	Meningitis B	
Twelve Months Old	Hib/Men C	
	Pneumococcal	
	MMR	
	Meningitis B Booster	
Preschool Booster (usually given at 3 years 4 months or soon after)	DTaP/IPV	
	MMR	
Girls aged 12 to 13 years	HPV (two doses 6-12 months apart)	
School Leavers Booster (usually given school year 9)	Td/IPV	
	MenACWY	
Legal Guardian (s)	1.	Same Household Y N
	2.	Same Household Y N
Other Adults in household	1.	2.
	3.	4.
Social Worker (if applicable)		

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Ethnicity - How would you describe your ethnicity?					
White	British	Irish	Other white		
Asian	Asian British	Bangladeshi	Indian	Pakistani	Other Asian
Black	Black British	African	Caribbean	Other black	
Mixed	Asian & White	Asian & Black	Asian & Caribbean	White African	White Caribbean
Other	Chinese	Japanese	Middle Eastern	Turkish	Any other ethnicity
Please advise us of your First Language			English	Other (<i>please state</i>)	

SMS Messaging Service		Yes	No
Would you like to receive text message appointment reminders and other notices from Clifton Medical Centre?			
I consent to receiving appointment confirmations, reminders and other notices via text messages and will update Clifton Medical Centre of any changes to my mobile number.	Signature	Date	
Online Services Clifton Medical Centre offers internet facilities for booking GP appointments and ordering repeat medication online. You need to be registered in order to access this service. You can only apply for yourself and must be aged 16 and over. If under the age of 16, then parental consent must be obtained. Do you want to be registered for the online services? If Yes, please sign the declaration below.		Yes	No
Please supply me with my Username and Password details to allow me to access the online appointment booking and repeat medication ordering services. I understand that I am responsible for securing these details to prevent unauthorised persons from accessing my record online. In the event that my security details have been compromised I will inform Clifton Medical Centre immediately so that access can be blocked and a new password issued. If at any time I wish to permanently cease internet access I will inform the practice in writing.			
Signature (Patient/Parent/Guardian)		Date	

Patient Participation Group (PPG)		
Clifton Medical Centre has a Patient Participation Group (PPG). If you are aged 14 and upwards and have any ideas you wish to share or are interested in joining our PPG please indicate whether you would like to help.		
I am interested in joining Clifton Medical Centre Patient Participation Group:	Yes	No