Fortune Green Practice

80 Fortune Green Road, London, NW6 1DS
Website: www.fortunegreenpractice.nhs.uk
Tel: 020 7472 5970 FAX: 020 7431 0789

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks. If you have not seen a doctor in the UK before, please produce your passport and form of address identification, such as a utility bill etc.

***Proof of Residence.* Yes☐ No☐**

[If you do not understand a question, or do not have appropriate information, please ask the nurse at your new patient check-up] (Please write in capital letters)

PERSONAL

Mr☐ Mrs☐ Miss☐ Ms☐

Surname: .... Forename(s): ....

Date of Birth: .... Marital status: ....

Address: ....

.... Postcode: .... Borough ....

Home Tel: .... Mobile: ....

Occupation .... Work Tel .... Email:..

Next of Kin..Tel.. Mobile..

Place of Birth:..................................Weight (approx.): .... Height:.................BP:.......................
(City or Town, and country)

Please inform us your Preferred Method of communication, Text☐ Email☐ Letter☐ Phone

ETHNIC GROUP (To which of following ethnic groups you feel you belong? Please tick or write your ethnic group)

White:
British☐ Irish☐ (...)
Any other White background

Asian or Asian British:
Pakistani☐ Indian☐ Bangladeshi☐ (...)
Any other Asian background

Black or Black British:
Caribbean☐ African☐ (...)
Any other black background

Mixed:
White and black Caribbean☐ White and black African☐ White and Asian☐

Chinese:☐ **Japanese:**☐ (...)
Any other ethnic background

what is your main spoken language? ....
Do you need an interpreter to help you with spoken English? Yes☐ No☐

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SMOKING

Do you smoke? Yes[.] No[.]

If Yes, how many:
Cigarettes per day …….. Cigars per day.……. Ounces of tobacco per day ……..
How old were you when you started smoking? …………………..

EX-SMOKERS

When did you stop smoking? …………………
How much did you smoke per day? …………………………………..

PASSIVE SMOKING
Are you exposed to smoke at work? Yes[.]No[.] At home? Yes[.] No[.]

ALCOHOL

1 Unit = 1/2 pint of beer or one small glass of wine or 1 single measure spirits

Do you drink Alcohol? Yes[.] No[.]

If Yes, how many units per week……….

For the following questions please tick the answer which best applies

ALCOHOL AUDIT -C

How often do you have a drink containing alcohol?
Never ( ) *Less than monthly ( )* *2-4 times per month ( )* *2-3 times per week ( )*
4+ times per week ( )

How many units of alcohol do you drink on a typical day when you are drinking?
1-2 ( ) *3-4 ( )* *5-6 ( )* *7-9 ( )* *10+ ( )*

Men: How often do you have **EIGHT** or more units on one occasion?
Never ( ) *Less than monthly ( )* *Monthly ( )* *Weekly ( )* *Daily or Almost Daily ( )*

Women: How often do you have **SIX** or more units on one occasion?
Never ( ) *Less than monthly ( )* *Monthly ( )* *Weekly ( )* *Daily or Almost Daily ( )*

EXERCISE

Do you take regular exercise? Yes[.] No[.]
If yes, what sort of exercise? ……………………………………………………………….
How many times per week? …………………………………………………………………..

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EATING

Do you have a special eating plan or diet?(e.g. diabetic, low fat, low salt, vegetarian, weight reducing etc.) if so, Please give details:………………………………………………………………………..
………

FAMILY HISTORY

Does any in your family ***(father, mother, brother, sister)*** have the following before age of 65?

Heart Disease (heart attacks, angina) Yes . No . if yes which family member? ……………………...

Cancer? Yes . No . if yes which family member? ……………………….

Diabetes? Yes . No . if yes which family member? ……………………….

Angina? Yes . No . if yes which family member? ………………………

Hypertension? Yes . No . if yes which family member? ………………………

Asthma? Yes . No . if yes which family member? ………………………

High Cholesterol? Yes . No . if yes which family member? ………………………

Any other? (………………………………) which family member?…………………………………………

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: …………………………………
Dosage: …………………………………………

Name of drug:…………………………
Dosage:…………………………………

Name of drug: …………………………………
Dosage: …………………………………………

Name of drug:…………………………..
Dosage:…………………………………

ALLERGIES

Are you allergic to any substances or foods? Yes. No.
If yes, please give details:
………
Are there any medicines or drugs you cannot take? Yes. No.
If yes, please give details:

………

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PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

………

Please give details of any treatment for any chronic medical conditions:

………

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

………

Do you take any homeopathic medication? If so please give details:……………………………………………..

Have you had surgery? If yes, Please give details:……………………………………………………………….

IMMUNISATIONS

Please give details of your last vaccinations

Dates of Triple/polio/HIB: ……………..…………Diphtheria……………BCG……………Measles………………

Dates of Whooping Cough: …………….Yellow fever………….Typhoid………..Cholera…………………………..

Date of last Tetanus: ………………………MMR……………………German measles………………………………………

Aged 15 and under only

Who is your primary carer? *Mother ( )* *Father ( )* *Other ( )*

Please give name……………………………………………………………..

What school do you attend? *Primary ( )* *Secondary ( )*

Please give name……………………………………………………………..

CARERS

Do you need / or have anyone who looks after you for your daily needs as Carer? Yes ☐. No ☐.

If "Yes", would you like them to deal with your health affairs here? Yes ☐. No ☐.
(The receptionist can help with these arrangements)

Do you care for anyone else? Yes ☐. No ☐.
If "Yes", ask the receptionist about Carers support

Name of the person you care for……………………………………………….Their contact No:……………………..

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FEMALE PATIENTS ONLY

Date of most recent cervical smear test: ……………..where was the test done? {Please tick}
Previous GP Surgery ( ) Clinic ( ) Private ( ). Was it Normal? Yes[.] No[.]

Result of most recent smear: ………………………………………………………………………………………..

Are you using contraception? Yes[.] No[.] If yes, what type……………………………………………...........

If you are on pills, what is the brand name?...

Are you on HRT? Yes[.] No[.] If yes what is the brand name?...

Do you know about emergency contraception? (If you require information please ask the Nurse)

Have you had hysterectomy? Yes[.] No[.] If so, please give date:-----------

If you are over 50

What was the date of your last mammogram?...................

Have you had any children? Yes[.] No[.] Give ages……………………………………………

Have you had a miscarriage? Yes[.] No[.] Give dates………………………………………….

Have you had a termination of pregnancy? Yes[.] No[.] Give dates………………………………………..

General

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details:...

………

………

Eye Sight

Do you have problems with your sight? Yes[.] No[.]

If yes, does it impact on your daily life? Yes[.] No[.]

Hearing

Do you have problems with your hearing? Yes[.] No[.]

If yes, does it impact on your daily life? Yes[.] No[.]

Name:……………………………………………………..Signature……………………………….Date:…………….

Your Named GP is Dr Sumara Nadeem
Please keep the practice informed of any changes in your personal details, such as address, Tel/mobile numbers etc. *Please Note: The information you give will be treated confidentially and is subject to the Data protection Act.*

Practice use only: **Allocated:** 9NN60 **Informed:** 67DJ.
Form Checked. [ ] ***Checked by:__***