**DUNDRUM AND CLOUGH SURGERY**

**NEW PATIENT QUESTIONNAIRE**

***PLEASE COMPLETE THIS FORM AND BRING IT WITH YOUR REGISTRATION DOCUMENTS.***

|  |  |
| --- | --- |
| **SURNAME** | **TITLE MR/MRS/MISS/MS (Please circle)** |
| **FORENAME(S)** | **PREVIOUS NAME** |
| **ADDRESS****POSTCODE** | **PREVIOUS ADDRESS(ES)** |
| **PHONE NO (HOME)** | **DATE OF BIRTH** | **PLACE OF BIRTH** |
| **PHONE NO (WORK)** |
| **MOBILE NO** | **PRESENT OCCUPATION**  |
| **EMAIL ADDRESS** |
| **NEXT OF KIN** | **NUMBER OF DEPENDENTS** | **ETHNIC ORIGIN** | **MARITAL STATUS** |
| **NAME & ADDRESS OF PREVIOUS GP** | **REASON FOR CHANGING GP** |
| **LIST ANY SERIOUS ILLNESSES, OPERATIONS, ACCIDENTS****1.** | **LIST ANY MEDICATIONS, INJECTIONS, TABLETS WHICH YOU ARE ON** |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** | **HAVE YOU ANY ALLERGIES? (Please circle)** **YES NO**  |
| **SOCIAL WORK INVOLVEMENT? (Please circle)** **YES NO** **IF YES, PLEASE GIVE DETAILS** | **ATTENDING HOSPITAL /OTHER HEALTH PROFESSIONAL? YES NO** **IF YES, PLEASE GIVE DETAILS** |
| **DO YOU DRINK ALCOHOL? (Please circle)** **YES NO** **HOW MANY UNITS PER WEEK?** | **WHAT IS YOUR HEIGHT?** | **WHAT IS YOUR WEIGHT?** |  |
| ***FOR WOMEN*** |
| **ARE YOU:- (Please tick box)** | **NUMBER OF CHILDREN GIVEN BIRTH TO** | **NUMBER OF MISCARRIAGES** |
|  | **A SMOKER IF YES, NUMBER PER DAY?** |
|  | **NON-SMOKER**  | **DO YOU USE A METHOD OF CONTRACEPTION?** |
|  | **EX-SMOKER**  |
| **ARE YOU A CARER? (Please circle)** **YES NO** **IF YES, PLEASE GIVE DETAILS**  | **DATE OF MOST RECENT*** **CERVICAL SMEAR**
* **BREAST SCAN/MAMMOGRAM**
 |
| **SIGNED: DATE:** |

***FOR GP USE***

**PAST MEDICAL HISTORY:**

**FAMILY HISTORY**:

Heart Disease Diabetes

Stroke Asthma

Cancer Others

**MEDICATION: ALLERGIES:**

B/P Reading:

Urinalysis:

Physical Examination:

Advice given:

Medical Card submitted: *(Please circle)* YES NO

Form HS200 submitted: *(Please circle)* YES NO

Date: