NEW PATIENT INFORMATION CARD

Date _____

Surname _____

First Name(s) _____

Full address _____

_____

_____

_____

Tel. no. home _____ work _____

Marital status _____ Date of Birth _____

Country of origin _____ Sex _____

Occupation _____

GENERAL HISTORY

Have you had any serious illnesses or operations, X-rays or similar tests and when? _____

_____

_____

_____

_____

Do you suffer from indigestion, e.g. heartburn? _____

What medicines are you taking? _____

_____

Have you any allergies to medicines or anything else? _____

_____

How much tobacco or cigarettes do you smoke? _____

How much alcohol do you consume per week? (quantity)

Wine _____ Beer _____ Spirits _____

FAMILY HISTORY **Please tick appropriate boxes**

Which of your blood relations have suffered from the following

Heart attack	☐ _____	Cancer	☐ _____
Diabetes	☐ _____	High Blood Pressure	☐ _____
Asthma	☐ _____	Tuberculosis	☐ _____
Stroke	☐ _____	Other serious illness	☐ _____

VACCINATIONS Which vaccinations have you had and when?

Diphtheria	☐ _____	Polio	☐ _____
German measles	☐ _____	Tetanus	☐ _____
Typhoid	☐ _____	Measles	☐ _____
Cholera	☐ _____	BCG	☐ _____
Yellow fever	☐ _____	MMR	☐ _____
Whooping cough	☐ _____	_____	☐ _____

FOR FEMALE PATIENTS ONLY

Have you had any children? ☐ give ages _____

Have you had a miscarriage? ☐ date _____

Have you had a termination of pregnancy? ☐ date _____

Have you had a hysterectomy? ☐ date _____

Which method of contraception are you using at present? _____

_____

When was your last smear test? _____

DO NOT COMPLETE THIS SECTION Date ☐

Urine ☐ Glucose ☐ Albumin ☐

BP ☐ Weight ☐ Height ☐

MEETING EVERYONE'S HEALTH NEEDS

We would be very grateful if you could take time to complete this form. Please remember any information given will be treated confidentially. If you have any queries about completing this form, please ask a member of staff. For question 1, if you feel you are descended from more than one group, please tick the one you most belong to, or choose the 'Any Other Ethnic Group' option. We are also asking your religion, preferred language, whether you have a disability, your smoking and alcohol status, if you are a carer and BMI (height and weight). Again this is to help us ensure we meet your health care needs appropriately.

Please hand in the completed form to staff.

THANK YOU.

1. What is your ethnic group?
Choose ONE section from A to E, and then tick the appropriate box to indicate your ethnic group.

A : White
- ☐ British
- ☐ Irish
- ☐ Any other White background (please write in)

……

B : Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed background (please write in)

……

C : Asian or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background (please write in)

……

D : Black or Black British
- ☐ Caribbean
- ☐ African
- ☐ Any other Black background (please write in)

……

E : Any Other Ethnic Group
- ☐ Chinese
- ☐ Vietnamese
- ☐ Any other (please write in)

……

F : Not stated
- ☐ Do not wish to state

2. Religion
What is your religion?
Tick one box only.

- ☐ None
- ☐ Church of England
- ☐ Roman Catholic
- ☐ Christian
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Islam
- ☐ Jehovah's Witness
- ☐ Any other religion (please write in)

……

- ☐ Not stated

3. What is your preferred language?
(please choose one)

	Written	Spoken
English	☐	☐
Vietnamese	☐	☐
Chinese	☐	☐
Hindi	☐	☐
Punjabi	☐	☐
Urdu	☐	☐
Cantonese	☐	☐
British sign language	☐	☐

Other (please describe)

……

4. Do you have a disability?

Yes ☐ No ☐

5. Do you have any information or communication needs?

☐ Braille ☐ Large Print ☐ Audio Tape

☐ Other (please give details) ……...

Preferred method of communication

☐ E-mail ☐ Letter ☐ Home telephone ☐ Work telephone ☐ Mobile telephone

Please state whether you wish to opt-in to the SMS messaging service ☐ Yes ☐ No

6. Please enter your current Smoking Status

☐ Never Smoked

☐ Current Smoker
Please enter amount of cigarettes/tobacco per day ……..

☐ Ex Smoker
Please select one of the following and enter date stopped:

☐	Ex light smoker (1 to 9 per day)	Date stopped ……/……/……
☐	Ex moderate smoker (10 to 19 per day)	Date stopped ……/……/……
☐	Ex heavy smoker (20 to 39 per day)	Date stopped ……/……/……
☐	Ex heavy smoker (40 plus per day)	Date stopped ……/……/……

7. BMI

Your BMI is calculated by using your Height and Weight, please enter if known. If you are unsure of your correct height and weight please ask at reception where a member of the practice team will arrange to measure your height and weight for you.

Height ……

Weight ……

8. Your details

In order for us to update your clinical records accurately please complete the following:

Family Name/Surname ……

Personal/First Name ……

Date of Birth ……/……/……

Date of completion ……/……/……

Please inform us immediately of any change of address or phone number.

Thank you for your cooperation