The Farnham Dene MEDICAL PRACTICE

New Patient Questionnaire

Date of Registration	
Date of Birth	

Surname	
First Names	
Address	Postcode
Please supply us with this information, it is very important, even if you are ex-directory. We also need to have your phone number to enable you to use the automated booking system.	Home Tel Work Tel:
	Mobile:
Email	

Present Occupation (or previous if retired or not working)

Marital Status | Sex M F | Height | Weight

Do you suffer from any of the following?

Asthma ☐ Epilepsy ☐ High Blood Pressure ☐
Cancer ☐ Heart Disease ☐ Mental Health Problems ☐
Stroke ☐ Thyroid Problems
Diabetes ☐ Emphysema/Chronic Lung Disease ☐

If yes, please give details

Do you smoke YES/NO?
If yes, how much and what?
If you have smoked in the past, please state how much and when you stopped.

On average, how much alcohol do you drink each week and what type?

What type and how much exercise do you take each week?

Do you have any allergies?

Has any close relation suffered from high blood pressure, heart disease, asthma, stroke, diabetes or another serious illness? **YES NO** If yes, please give details including age at onset of problems.

Do you look after someone or does someone look after you?

FEMALES ONLY
Please give the date of your most recent cervical smear and state where it was taken and if by your GP.

Please list any regular medication including inhalers prescribed by your previous doctor.

Drug Name **Dose / Day**

We need to ask about your ethnicity. Please tick one of the boxes and enter first language below.

British or Mixed British ☐ Caribbean or Mixed Caribbean ☐
African or Mixed African ☐ Indian or Mixed Indian ☐
Asian or Mixed Asian ☐ Other ☐

Main language spoken

Any additional information?