

Your New Patient Check appointment is on _____ at _____

LAKESIDE MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

Name: _____

Date of Birth: _____

Address: _____

Post Code _____ Email: _____

Tel No: Home _____ Work: _____ Mobile: _____

Do you smoke? Never Smoked Ex-Smoker Yes How many?

Do you drink alcohol? None/Never Yes

How much do you drink on average per week?

	Less than one	1-5 Glasses or 1-3 Pints	6-10 Glasses or 4-6 Pints	11-15 Glasses or 7-9 Pints	16-20 Glasses or 10 or more Pints
Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you take regular exercise? Yes No

Do you have a healthy diet?
(i.e. low fat, low sugar & high fibre) Yes No

Are you currently on any medication? Yes No

If Yes, Please list in the box:

Have you ever been prescribed antidepressants? Yes No

Do you suffer from any Allergies? Yes No

If yes please give details below:

Do you suffer/or have you ever suffered from any of the following?

Heart Attack/Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma/COPD	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please list below any current or significant past medical history (i.e. hospital admissions):

Are any of your close relatives (mother, father, brother or sister) suffering with/or suffered from any of the following?

Heart Attack/Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:
Asthma/COPD	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:

Have any of your close relatives died from either of the following?

Heart Attack/Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/> Relationship:

Signed.....Date.....

Please bring this form and a urine sample (bottle attached) to your New Patient Check. This will be carried out at the Health Centre by one of our Practice Nurses.

****It is important that you undertake this check before you require a Doctor's appointment.****