FRAMLINGHAM MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE

Surname:		Previous Name:		
First Name(s)		Male		Age:
Date of Birth		Female		
Place of Birth		NHS No:		
Address:				
Post Code:		Telephone No:		
Mobile No		Work No:		
	I am happy to be contacted by text.	Please circle YES NO		
Email:				
Next of kin:		Telephone No:		
Relationship:				

Are you a carer for someone	Yes	No	**Is someone a carer for you:**	Yes	No
Please speak to Reception about Suffolk Family Carers					

Which Ethnic Origin Group do you belong to?	**Please Tick**	**Which Ethnic Origin Group do you belong to:**	**Please Tick**
White British		Bangladeshi/British Bangladeshi	
White Irish		Chinese	
Gypsy/Romany		Other Asian background	
Other white background		African	
White and Black Caribbean		Caribbean	
White and Black African		Other black background	
White and Asian		Arab	
Other mixed background		Other	
Indian/British Indian		Ethnic group not given – patient declined	
Pakistani/British Pakistani			

Please advise us of your First Language			
English		Other (which language do you use instead?)	

Please indicate with a tick if you have ever had any of the following:

High Blood Pressure		**Asthma**	
Angina		**Chronic bronchitis**	
Heart Attack		**Depression**	
Stroke(s)		**Manic Depression**	
Diabetes		**Schizophrenia**	
Underactive thyroid (Hypothyroidism)		**Epilepsy**	

Please list your current medication below:

Name of tablet	Dose	How often do you take it	Reason

We would appreciate a copy of your repeat prescription list for our records. If you are on regular medication you will need an appointment with our nurse or doctor.

	Yes	No
Do you take ALL the medicines listed on your repeat slip?		
If not, which do you no longer take?		
Do you know what each of your medicines is for and when to take them?		
Do you ever forget to take your medicines?		
Do you experience any problems opening the packaging or taking your medicines?		
Do you take any other medicines including any that you buy over the counter? If so please tell us what they are:		

For non-dispensing patients only (patients living within a mile of a pharmacy)
Please speak to a member of the Reception team about your prescription.

PRACTICE USE ONLY

Thank you for completing this form, the information will be entered onto our clinical system to help the Doctors and Nurses give you the best treatment/advice possible and remains completely confidential.