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		I am happy to be contacted by text. Please circle YES NO	Work No:		
Email:					
Next of kin:			Telephone No:		
Relationship:					

Are you a carer for someone	Yes	No	**Is someone a carer for you:**	Yes	No

Which Ethnic Origin Group do you belong to?	**Please Tick**	**Which Ethnic Origin Group do you belong to:**	**Please Tick**
British/Mixed		Pakistani/British	
Irish		Bangladeshi/British	
Other White		Other Asian	
White and Black Caribbean		Caribbean	
White and Black African		African	
White and Asian		Other Black	
Other Mixed		Chinese	
Indian/British		Ethnic group not given – patient refused	

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

Do you suffer from any allergies?	YES	NO
Please list them:		

DO YOU SMOKE?	Never?			
	Ex smoker?		If yes, give date you gave up?	
	Current smoker?		Would you like help to give up?	
	How many a day?			

How often do you have a drink containing alcohol?			**How many drinks containing alcohol do you have on a typical day when you are drinking?**			**How often do you have six or more drinks on one occasion?**		
	√			√			√	
Never		0	1 or 2		0	Never		0
Monthly or less		1	3 or 4		1	Less than monthly		1
2-3 times a month		2	5 or 6		2	Monthly		2
2-3 times a week		3	7, 8 or 9		3	Weekly		3
4 or more times a week		4	10 or more		4	Daily or almost daily		4

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.

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:

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.