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New Patient Registration/Health Questionnaire

Personal Details

v.2015-10

Name……..DOB……

Contact no: Home……..Mobile……

Email…… Next of kin/Carer……

Marital Status……. Occupation……

Ethnicity…….. Preferred Language……

Interpreter required **Yes [ ] NO [ ]** Religion ……..

[ ]Religion **None** (code **135D)** **[ ]**Religion **Do not wish to answer** (code **135Q**)

Preferred method of communication: **[ ]Phone** Best tel.no. ……

[ ]Email [ ]Fax Fax no…… **[ ]Letter [ ]No preference**

I am giving my consent to contact me by either

Telephone **Yes [ ] NO [ ]** Email **Yes [ ] NO [ ]** Text Msg **Yes [ ] NO [ ]**

(Admin staff please enter the read code **9NdP** for **Yes** and **9NdQ** for **NO**)

Health Information

Smoking

Do you Smoke? **Yes [ ] NO [ ]** If **yes**, Cigarette [ ] Cigar [ ] Rolls [ ] Pipe [ ]

How many do you smoke a day? **[ ]**

Are you considering stopping smoking? **Yes [ ] NO [ ]**

If **Yes,** please make an appointment with practice nurse.

Diet

Are you vegetarian? **Yes [ ] NO [ ]**

Do you have varied diet including milk, meat, Vegetable and fruit? **Yes [ ] NO [ ]**

Do you add salt to your food after cooking? **Yes [ ] NO [ ]**

Exercise

Do you exercise? **Yes [ ] NO [ ]**

If **Yes,** How many times in a week and what do you do? ……

Allergy

Are you allergic to any medicine? **Yes [ ] NO [ ]** If Yes, Please write……

Are you allergic to any food? **Yes [ ] NO [ ]** If Yes, Please write……