WELLFIELD HEALTH CENTRE
NEW PATIENT REGISTRATION QUESTIONNAIRE

PATIENT DETAILS

Title	□Mr □Mrs □Miss □Ms	Surname	
Date of Birth		First Names	
Occupation		Previous Surnames	
Home Address: Postcode:		Home Tel:	
		Work Tel:	
		Mobile Tel: Are you happy to receive appointment reminders etc via text message:	□Yes □No
		Email	
Next of Kin:		Name:	Telephone No:

What is your first language:	
Do you need an interpreter for your appointments:	□Yes □ No

Are you a military veteran:	□ Yes □ No

Name and Address of Previous GP:

ETHNIC GROUP

White	□ British □ Irish □ Other (please specify)
Black	□ Caribbean □ African □ Other (please specify)
Asian	□ Indian □ Pakistani □ Chinese □ Other (please specify)
Mixed	□ White + Black Caribbean □ White + Black African
	□ White + Asian □ Other (please specify)

PROOF OF IDENTITY AND ADDRESS PROVIDED

□ Birth Certificate	□ Driving Licence	□ Passport	□ Utility Bill
□ Allowance Book	□ Solicitor's Letter	□ Offer of Tenancy	□ Other

MEDICAL INFORMATION

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place			
Have you ever suffered from? (tick as appropriate)			
Epilepsy	□ Yes □ No	Blindness/Glaucoma	□ Yes □ No
High Blood Pressure	□ Yes □ No	Diabetes	□ Yes □ No
Heart Attack/Stroke	□ Yes □ No	Depression	□ Yes □ No
Cancer	□ Yes □ No	Asthma	□ Yes □ No
Eczema/Hay Fever	□ Yes □ No	COPD	□ Yes □ No

Please list any medicines being taken and the amount:
This practice uses EPS (Electronic Prescription Service). If you already have a nominated pharmacy, please note any prescription requests will be sent automatically. If you need to change your nominated pharmacy, please inform the receptionist as soon as possible.

Are you registered disabled? (If yes, please give details)	□ Yes □ No

Are you allergic to any medicines and if so, which?	□ Yes □ No

CARERS

Do you have a carer? (If yes, please give details)	□ Yes □ No

Are you a carer? (If yes, please give details)	□ Yes □ No

SMOKING

Do you smoke? □ Yes □ No
If 'No', have you ever smoked? □ Yes □ No
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?
Would you like advice on giving up smoking? □ Yes □ No

ALCOHOL

Do you drink alcohol? □ Yes □ No
If yes, how much per week do you drink? (1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits)

HEIGHT & WEIGHT

What is your height:	
What is your weight:	

DIET & EXERCISE

Do you consider your diet: □ Good □ Average □ Poor
Do you exercise? □ Yes □ No
Type of exercise:
How many hours per week do you exercise?

FOR PATIENTS AGED 65 AND OVER OR THOSE WITH A CHRONIC DIEASE (E.G ASTHMA OR DIABETES)

Have you ever had a flu vaccination? (Enter date or 'never')	
Have you had a pneumococcal vaccination? (Enter date or 'never')	

Signature	Date

Thank you for taking the time to complete this questionnaire, the information you have supplied will help improve our service to you.