**Mendlesham Medical Group New Patient Questionnaire**

Please complete the following questionnaire to the best of your knowledge. This information will help us provide you with concise medical care.

**Personal information:**

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| --- | --- |
| **Title *(please circle):*** | MR MRS MS OTHER *(please specify)* |
| **Full name:**  | **Date of Birth:** |
| **Address:****Postcode:** |
| **Place of birth:** | **First language:**  |
| **Ethnicity:** | **Marital status:** |
| **Telephone number:** | **Occupation:** |
| **Telephone number** (*landline/ alternative)***:** | **Email address:** |
| **Consent to be contacted via SMS or email (*please circle)*:**  Yes/ No |

|  |  |
| --- | --- |
| **Name and relationship:** | **Contact details:** |
| **Name and relationship:** | **Contact details:** |

**Next of kin:**

**Carer:**

|  |  |
| --- | --- |
| **Are you a family carer?** *(please circle)*:Yes/ No | **Do you have a family carer?** *(please circle):* Yes/ No  |
| If you do have a family carer please provide name and contact details: |

**Your health:**

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| **Past medical history including serious illnesses, long term conditions, major operations and disabilities:** |
| **Any medications that you are taking currently***(including GP prescribed, hospital prescribed and herbal)***:** |
| **Any drug or food allergies and/ or sensitivities:** |

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| Do any conditions run in the family such as diabetes, heart disease, blood pressure, asthma, glaucoma, or stroke? *(please specify family members):*  |

**Relevant family medical history:**

**Personal health:**

|  |  |  |
| --- | --- | --- |
| **Recent Blood pressure reading:** | **Weight:** | **Height:** |
| **Smoking status** *(please circle):* Smoker/ E-cigarette/ vape/ Ex-smoker/ Never smoked | **Current smoker:**Yes/ No**How many a day:**  |
| **If you are a current smoker would you like cessation advice? :** Yes/ No  | **If you have quit smoking date you gave up:** |
| **How often do you consume a drink containing alcohol?** *(please circle)*: Never/ Monthly or less/ 2-4 times a month/ 2-3 times a week/ 4 or more times a week | **How many units of alcohol do you drink on a typical day when drinking?** : |
| **How often have you had 6 or more units if female/ or 8 or more if male, on a single occasion in the last year?** :  | ***Ref:*** *175ml of wine= 2 units, 1 pint of beer= 2 units**Alcopop/ can of lager= 1.5 units, single measure of spirits= 1 unit*  |

**Immunisations:**

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| **Have you been immunised against:*** Tetanus
* Diphtheria
* Polio
* Whooping cough
* Measles
* Mumps
* Rubella (German measles)
* Tuberculosis

*For children please bring red book along to appointments*  |

**For women:**

|  |  |
| --- | --- |
| **Are you currently using contraception?** *(please specify)* : | **Are you currently pregnant?** : |

**Relevant family medical history:**

**Children:**

|  |
| --- |
| *(Please state names and dates of birth of any children you have)* |