CITY WALLS MEDICAL CENTRE/SAUGHALL MEDICAL CENTRE
PATIENT QUESTIONNAIRE

PERSONAL DETAILS **Date:** / /

Title: Mr / Mrs / Ms / Other: ……..... Surname: …….. First Name(s): …….

Date of Birth: / / Marital Status: ……. Occupation: ……

Address: …… …… Previous Address: …….... ……...

Post Code: …… Post Code: ……

Telephone: …… Mobile: ……

Place of Birth: …… Country of Origin: ……

Previous Practice in UK and reason for change: ……...

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ETHNIC ORIGIN

White: British ☐ Irish ☐
Other White Background (please specify): ……

Mixed: White / Black Caribbean ☐ White / Black African ☐ White / Asian ☐
Other Mixed Background (please specify): ……...

Black: British ☐ Caribbean ☐ African ☐
Other Black Background (please specify): ……

Asian or Asian British: British ☐ Irish ☐
Other White Background (please specify): ……

Other Unlisted: Other (please specify): ……

Main Spoken Language: ……..

NEXT OF KIN

Name: …… Relationship: ……

Telephone: …… Mobile: ……

PERSONAL MEDICAL AND SOCIAL HISTORY

Are you allergic to anything? Yes / No
Drugs: ……
Other: ……

Do you smoke?

Yes ☐ What do you smoke? Cigarettes ☐ Cigars ☐ Pipe ☐
How much do you smoke each day? ……cigarettes/oz

Ex-Smoker ☐ When did you stop? ……

Never Smoked ☐

Do you exercise each week?	Impossible ☐ None ☐ Light ☐		Moderate ☐ Strenuous ☐ Athlete ☐	
Are you a carer? (Do you care for a family member of friend?)	Yes ☐	Relationship to person: …….. Are they registered at City Walls? Yes / No		
	No ☐			
Do you have a carer?	Yes ☐	Carer's Name: …… Telephone: ……...		
	No ☐			

Do you suffer from or have a history of:

Heart Attack / Angina	☐	Stroke	☐	Diabetes	☐		
Asthma / COPD	☐	Thyroid Problems	☐	Blood Pressure	☐		
Mental Illness	☐	Glaucoma	☐	Cancer	☐	Epilepsy	☐

Do you consider yourself to have a disability that we need to be aware of to ensure all your needs are met when you visit the practice?

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FAMILY HISTORY

Has any close relative (brother, sister, parent) suffered from: (please also specify who)

Heart Attack	☐	Heart Disease before age 60	☐	Heart Disease after age 60	☐
Stroke	☐	Breast Cancer	☐	Asthma	☐
Diabetes	☐	High Blood Pressure	☐	Raised Cholesterol	☐

FEMALE PATIENTS ONLY

Do you have either of these methods of contraception fitted?

Mirena Coil ☐ Ring Pessary ☐

Approximately which month and year was it fitted? ……

If not, what form of contraception (if any) do you use? ……

When was your last smear? ……

In accordance with the new Data Protection Regulations introduced on 25th May 2018, can you confirm that you consent to being contacted by the surgery via text message or email and for your details to be kept on our database. ☐

As a practice, we recommend you take regular exercise (e.g. cycling, swimming, aerobics, resistance training) 3 times per week, along with a sensible balanced diet. We also recommend you have regular blood pressure check. Please attend yearly for this. Smokers are strongly advised to stop.

STAFF ONLY TO COMPLETE

Photo ID

Passport ☐
I.D. Card ☐
Driver's License ☐

Other (please specify) ……

Verified By: …… Signature: ……