Today's Date:

Ivel Medical Centre
New Patient Questionnaire

Please complete this confidential questionnaire (**one for each member of the family** to be registered with the Practice).

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

IF YOU ARE ON ANY REGULAR PRESCRIBED MEDICINES PLEASE TICK HERE ☐

For Reception – Please make Doctor's appointment

Full Name:					**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..					**Work Number**
Address and Postcode					**Mobile Number:**
					E-mail Address:
					Next of Kin name and relationship:
					Next of Kin Contact Number:
Town & Country of Birth:					
Date of Birth:					
Marital Status:					**Other residents of your home:**
Gender:	Male:	Female:	Not Stated:		
Occupation:					
Names & Ages of Children					
					NHS Number (If Known)
Are you on the Organ Donor Register?		**Yes**			**No**
Have you served in the Armed Forces?		**Yes**			**No**

Your height:	**Feet / inches**	**cm**	**Your weight:**	**Stones / lbs.**	**kg**

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated**

Your main or 1st language Spoken / Understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?					
How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer) see attached guidance*					
How often do you exercise?	**No. times per week**		**Type(s) of exercise:**		

Your Medical Background:

What illnesses have you had & when?	
What operations have you had and when?	

Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**
Do you have any allergies or drug sensitivities?	**No**	**Yes – please give details**

<table>
<tr><td rowspan="3">Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)</td><td>Diabetes</td><td>Heart Attack</td><td>Heart attack under age of 60</td><td colspan="2">Bowel Cancer</td></tr>
<tr><td colspan="2">Breast Cancer</td><td>High Blood Pressure</td><td>Asthma</td><td>Stroke</td></tr>
<tr><td colspan="2">Other Cancer</td><td colspan="3">Any other important Family Illness?</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Specific Needs:
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:</td></tr>
<tr><td colspan="2">Please state any Sensory Impairment you have (i.e. Speech and Hearing):</td><td colspan="4"></td></tr>
<tr><td colspan="2">Do you wear glasses?</td><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td colspan="2">Have you had any other problems with your eyes other than wearing glasses? If yes please advise your optician to write to us</td><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td colspan="2">Are you an ‘Assistance Dog’ User?</td><td colspan="4"></td></tr>
<tr><td colspan="2">Please state any Physical disabilities you have:</td><td colspan="4"></td></tr>
<tr><td colspan="2">Please state any Mental disabilities you have:</td><td colspan="4"></td></tr>
</table>

Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
If you are a Carer, please state the name / address / phone number of the person you care for:	Person Cared For Contact Details:
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	Carer Contact Details: Signed: Date:

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If "Yes", can you please provide a written copy of it*
Have you nominated someone to speak on your behalf?	Yes / No	If "Yes", please state their name / address / phone number and provide us with e.g. copy of Power of Attorney or a letter of authorisation:

Women only:

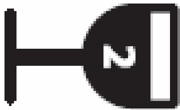
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

Thank you for completing this form. ***For more information about the services we offer, see our website: www.ivelmedicalcentre.co.uk***

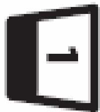
UNITS

Pint of Regular Beer/Lager/Cider

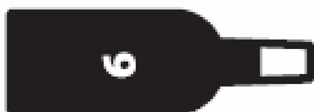
Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine