Roslea Surgery
51 Station Road, Bamber Bridge, Preston, PR5 6PE
p: (01772) 310100
w: www.rosleasurgery.co.uk
fb: www.facebook.com/RosleaSurgery

NEW PATIENT MEDICAL
Date:
Time:
With:

ADULT – NEW PATIENT HEALTH QUESTIONNAIRE

PERSONAL DETAILS

All questions are strictly confidential and will become part of your medical record.

Surname:	DOB:
Given Name:	☐ M ☐ F
Address:	Postcode:
Home Number:	Work Number:
Mobile Number:	Email:

It is your responsibility to inform us of any changes to your contact details.
By providing the above information you are consenting to allow us to use these methods to contact you.

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Widowed

Ethnicity: (please check all that apply)	White ☐ Mixed	Asian ☐ Mixed	Black ☐ Mixed
	☐ British	☐ Indian	☐ Caribbean
	☐ Irish	☐ Pakistani	☐ African
	☐ Other: Please specify below _____	☐ Other: Please specify below _____	☐ Other: Please specify below _____

Town/City & Country of Birth:	Occupation:

Name & address of previous GP:

REQUIRED Proof of Identity and Proof of Address:	Identity ☐ Passport ☐ Driving Licence ☐ Warrant Card ☐ Bus Pass ☐ Other	Proof seen by staff: (Initials) _____ (Please take copy)	Address ☐ Utility Bill ☐ Council Tax Bill ☐ Mobile Bill ☐ Bank Statement ☐ Other	Proof seen by staff: (Initials) _____ (Do not copy)

Are you registered disabled? ☐ Yes ☐ No	Are you a paid/unpaid Carer? ☐ Y ☐ N or Do you have a paid/unpaid Carer? ☐ Y ☐ N If yes to either of the above, please state person's name, number and relationship to patient below. Name: Number: Rel:

Emergency Contact:	Name:	Relationship to Patient:
	Home No:	Mobile No:
Next of Kin:	Name:	Relationship to Patient:
	Home No:	Mobile No:

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FAMILY MEMBERS LIVING AT YOUR ADDRESS All questions are strictly confidential and will become part of your medical record.		
Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:

Please use back of page if you need more room for family members

FAMILY HEALTH HISTORY All questions are strictly confidential and will become part of your medical record.							
		Age	Significant Health Problems			Age	Significant Health Problems
Father				Sibling	☐ M ☐ F		
Mother				Sibling	☐ M ☐ F		
Child	☐ M ☐ F			Sibling	☐ M ☐ F		
Child	☐ M ☐ F			Sibling	☐ M ☐ F		
Child	☐ M ☐ F			Grandmother *Maternal*			
Child	☐ M ☐ F			Grandfather *Maternal*			
Child	☐ M ☐ F			Grandmother *Paternal*			
Child	☐ M ☐ F			Grandfather *Paternal*			

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PERSONAL HEALTH HISTORY

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If you tick any of the below, please state year you were first diagnosed next to it.

Have you ever suffered from any of the following? (Tick all that apply)	☐ Epilepsy ☐ COPD ☐ Atrial Fibrillation ☐ Rheumatoid Disease ☐ High Blood Pressure ☐ Diabetes	☐ Angina ☐ Heart Attack ☐ Stroke ☐ Depression ☐ Heart Failure ☐ Cancer	☐ Glaucoma ☐ Vascular Disease ☐ Eczema ☐ Asthma ☐ Heart Attack

NOMINATED PHARMACY FOR ELECTRONIC PRESCRIPTIONS:

	Name of Medication:	Strength:	Frequency taken:
Current Medications:			

	Name of Medication:	Reactions you had:
Allergies to Medications		

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HEALTH HABITS & PERSONAL SAFETY

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Exercise:	☐ Sedentary (No Exercise) ☐ Mild Exercise (i.e. climb stairs, walk 3 blocks, play golf occasionally) ☐ Occasional vigorous exercise (i.e. work/recreation less than 4x per week for 30 min) ☐ Regular vigorous exercise (i.e. work/recreation 4x per week or more for 30 min)	
Alcohol:	Do you drink alcohol? If yes, what kind? How many units of alcohol per week? Are you concerned about the amount you drink? Have you considered stopping drinking? Have you ever experienced blackouts? Are you prone to binge drinking? Do you drive after drinking?	☐ Yes ☐ No Kind: _____ Units: _____ ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Pint of Beer/Lager/Cider	Alcopop/Can of Lager	Glass of wine (175 ml)	Single Measure of Spirits	Bottle of wine
2 units	1.5 units	2 units	1 unit	9 units

Tobacco:	Do you use tobacco? If no, have you ever used tobacco? If yes, number of years used If yes, year you quit using ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars If you use tobacco, are you interested in help to stop?	☐ Yes ☐ No ☐ Yes ☐ No Number of years: _____ Year quit: _____ Cigarettes per day: _____ Amount per day: _____ Amount per day: _____ Number per day: _____ ☐ Yes
Personal Safety	Do you live alone? Do you have frequent falls? Do you have vision loss? Do you have hearing loss? Do you have an Enduring Power of Attorney? Do you have a Living Will?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

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REGISTER FOR ONLINE SERVICES

Please contact reception

Patients requesting to register for online services must present themselves and provide two acceptable forms of identification before being able to register.

This allows you to order Repeat Prescriptions book a GP Appointments online.

First form of identification **must** be a photo ID

Examples are:

- Passport
- Driving licence (full or provisional)
- Bus pass
- ID card
- Warrant card

Please note:

Work ID cards, even with photo, are not an acceptable form of ID.
National Insurance cards are not an acceptable form of ID.

Second form of identification is proof of address.

Examples are:

- Driving licence (full or provisional)
- Utility bill
- Council Tax bill
- Mobile phone statement
- Bank statement

Please note:

It must contain the patient's name, an address that matches the one we have held on the patient's medical record and have been received within the last three months.

This list is not exhaustive.