THE BARNARD MEDICAL GROUP - NEW PATIENT QUESTIONNAIRE

PATIENT DETAILS		
First Name	**Surname**	**Date of Birth**
Home Address		
Male ☐ **Female** ☐	**Title**	**Previous Surname**
Home Telephone	**Mobile**	
Email		
Barnard Medical Group offers a text messaging service to contact its patients about appointment reminders and health promotion would you like to be included in this service using the mobile number given above? **Yes** ☐ **No** ☐		
Can we use the above email address provided to contact you in the future? **Yes** ☐ **No** ☐		
Marital Status:	**Occupation:**	
First Language Spoken: **English** ☐ **Other** ☐ **Please state:**		

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NEXT OF KIN DETAILS	
Full Name:	**Relationship:**
Contact Details:	

PATIENTS WITH A REGISTERED VISUAL OR HEARING IMPAIRMENT
Which form of communiction is best for you to be contacted by: **Text** ☐ **Email** ☐ **Fax** ☐ **Telephone** ☐ **Written** ☐ **Large Print (Written)** ☐ **Other Requirments:**

CARER INFORMATION	
Are you a carer or registered as a carer? **Yes** ☐ **No** ☐	**Do you live with the person you care for?** **Yes** ☐ **No** ☐
If they are registered at Barnard Medical Group please give details: **Name:** **Address:**	**Are they a family member?** **Yes** ☐ **No** ☐ **Relationship:**

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PARENTS WHO HAVE CHILDREN (Under 16 Only)	
Do you have any children under 16 living with you? Yes ☐ No ☐	**If YES how Many?**
Please state if their Surname is different to yours:	

ETHNICITY

White	Asian	Black/Black British	Other	Not Stated
British ☐	Indian ☐	Caribbean ☐	Chinese ☐	Prefer not to answer ☐
Irish ☐	Pakistan ☐	African ☐	Other ethnic ☐	
Other ☐	Bangladeshi ☐	Other ☐		
	Other ☐			

LIFE STYLE

Smoking Status	Cigarette Smoker ☐ How many do you smoke daily? _____ Cigar Smoker ☐ How many do you smoke daily? _____		Ex Smoker ☐ Quit Date: _____	Never Smoked ☐
Alcohol Consumption	How Many glasses/ pints or single measures of Alcohol do you drink on average each week? Wine:	Beer:	Spirits:	Ex-Drinker ☐ Teetotaller ☐
Exercise	Do you undertake any regular exercise? Yes ☐ No ☐	What type of exercise do you do? (please state)		How many hours per week?

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IMMUNISATIONS

Tetanus	Polio	Diptheria	BCG	Other
Date:	Date:	Date:	Date:	Date:

MEDICAL AND DRUG INFORMATION

Do you suffer from any of the following conditions:

Asthma ☐ COPD ☐ Diabetes ☐ Epilepsy ☐ High Cholesterol ☐ High Blood Pressure ☐

Heart Attack ☐ Cancer ☐ Glaucoma ☐ Stroke ☐ Tuberculosis ☐ Thyroid problems ☐

Do you suffer from any of the following Mental Health Problems:

Depression ☐ Anxiety ☐ Bi Polar Disorder ☐ Other ☐ (please state)

Please list any serious illnesses/ operations/ accidents/ disabilities (with dates):

Please list all regular medication and doses (Alternativly please attach a copy of your repeat prescription form):

Are you Allergic to any medication?	Any other Allergies known?
Yes ☐ **(If yes please list)** **No** ☐	**Yes** ☐ **(If yes please list)** **No** ☐

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FAMILY HISTORY

Does anyone in your family suffer from any of the following conditions? (Please Delete as appropriate)

Heart Attack or Angina		**Stroke**		**Diabetes**	
Mother / Father	Under 60 / Over 60	Mother / Father	Under 60 / Over 60	Mother / Father	Under 60 / Over 60
Brother / Sister	Under 60 / Over 60	Brother / Sister	Under 60 / Over 60	Brother / Sister	Under 60 / Over 60
Aunt / Uncle	Under 60 / Over 60	Aunt / Uncle	Under 60 / Over 60	Aunt / Uncle	Under 60 / Over 60
Asthma		**High blood Pressure**		**Cancer**	
Mother / Father	Under 60 / Over 60	Mother / Father	Under 60 / Over 60	Mother / Father	Under 60 / Over 60
Brother / Sister	Under 60 / Over 60	Brother / Sister	Under 60 / Over 60	Brother / Sister	Under 60 / Over 60
Aunt / Uncle	Under 60 / Over 60	Aunt / Uncle	Under 60 / Over 60	Aunt / Uncle	Under 60 / Over 60
Epilepsy		Any other relevant family history:			
Mother / Father	Under 60 / Over 60				
Brother / Sister	Under 60 / Over 60				
Aunt / Uncle	Under 60 / Over 60				

FEMALE PATIENT'S ONLY

Have you ever had a smear?	**Yes**	**No**	**Result:**	
Have you ever had an abnormal smear?	**Yes**	**No**	**Date:**	
Have you had a hysterectomy?	**Yes**	**No**	**Date:**	
Are you on HRT?	**Yes**	**No**	**Type:**	
Current method of contraception:			**Number of Pregnancies:**	
Have you ever had a mammogram?	**Yes**	**No**	**Date:**	**Result:**

THANK YOU FOR COMPLETING YOUR NEW PATIENT QUESTIONNAIRE