the Pulteney Practice

New Patient Questionnaire

Name: _____

Date of Birth: __ / __ / ____

Postcode: _____

Email Address: _____

Mobile Telephone No: _____

Work Telephone No: _____

Marital Status

Single	☐	Separated	☐
Married	☐	Divorced	☐
Common Law Partnership	☐	Rather Not Say	☐
Widowed	☐		

Ethnic Origin

White British	☐	Other White	☐
White & Black Caribbean	☐	White & Black African	☐
White & Asian	☐	Mixed Race	☐
Indian	☐	Pakistani	☐
Bangladeshi	☐	Other Asian	☐
Caribbean	☐	African	☐
Other Black	☐	Chinese	☐
Traveller	☐	Other (not elsewhere specified)	☐

Next of Kin

Please provide next of kin's full name, address and telephone number (state your relationship e.g. mother):

Note for staff if no relationship stated select other

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Height: _____ cm/feet & inches (please delete as appropriate)

Weight: _____ kg/stones & pounds (please delete as appropriate)

Home Blood Pressure Reading (most recent): ____ systolic ____ diastolic. Date of reading: __ / __ / ____

Influenza Vaccination (if eligible), Date of Last Vaccination: __ / __ / ____

Pregnant? (females only) ☐ Estimated Date of Delivery: __ / __ / ____

Smoking Status

Smoker ☐ Ex-Smoker ☐

Never Smoked Tobacco ☐

If smoker, cigarette consumption: _____ cigarettes per day

If smoker, tick if you would like to be referred to a stop smoking advisor ☐

Family History

Do you have parents, brothers or sisters with the following:

Family History of Diabetes Mellitus ☐

Family History of Heart Disease ☐

Family History of Stroke ☐

Family History of Colon Cancer ☐

Family History of Breast Cancer ☐

Family History of Thyroid Disorder ☐

Family History of Heart Attack ☐

Any other important family illnesses?

Past Medical History

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Allergies and Sensitivities

Please list any allergies and sensitivities:

Prescriptions

Please list any current medication:

Where would you normally prefer to collect your prescriptions? (please only tick one)

Pulteney St Surgery Reception	☐	Bathampton Surgery Reception	☐
Pulteney St Pharmacy	☐	Bathampton Pharmacy	☐

Other (please state pharmacy name): _____

Do you have any communication or access needs? (Large print documents,,British Sign Language interpreters, require the use of wheelchair ramps etc.) If yes, please state below:
