BLACKFRIARS MEDICAL PRACTICE

New Patient Questionnaire
Adults aged over 18 years of age

PERSONAL DETAILS		
Name: **Alternative name(s):**		**Date of Birth:** **NHS Number (If Known):**
Email address		
Marital Status (*Please circle)*	Single Married Co-habiting Divorced Separated Widowed	
Occupation:		
Religion (*Please circle)*	Christian Buddhist Hindu Jewish Muslim Sikh Any other religion, please describe:	
Which of the Following best describes how you think of yourself (*Please circle)*	Woman (including trans woman) Man (Including trans man) Non Binary In another way (please state)	
Is your Gender the same as you were given at birth?	Yes No	
Sexual Orientation	Lesbian Bisexual Gay Heterosexual	
Do you consider yourself to have a disability	No Yes: Physical Sensory Learning Disability Mental Health Other:	
Have you ever served in the armed forces?		
Ethnicity	**White**	**Mixed/Multiple ethnic groups**

(*Please circle)*	British Irish Gypsy or Irish Traveller Any other White background, please describe:	White and Black Caribbean White and Black African White and Asian Any other Mixed/Multiple ethnic background, please describe:
	Asian/Asian British Indian Pakistani Bangladeshi Chinese Any other Asian background, please describe:	**Black/ African/Caribbean/Black British** African Caribbean Any other Black/African/Caribbean background, please describe:
		Other ethnic group Arab Any other ethnic group, please describe:

First language:	**Immigration status:**
Do you come from a community known to practice FGM: **Have you undergone FGM:** **Do you have any children at risk of FGM:**	

COMMUNICATION REQUIREMENTS		
Do you require any of the following: *(Please circle all that apply)*	I need an Interpreter	I need large print
	I use lip reading	I rely on British Sign Language
	I use text phone / Mincom	No requirement

NEXT OF KIN / FAMILY DETAILS			
Next of Kin	**Name:**	**Contact Number:**	**Relationship to you:**

Do you have any children/dependents:	Yes / No *(If yes please fill in section below)*

Child name: **Child DOB:** **Child Address** *if different to yours:*	**Child name:** **Child DOB:** **Child Address** *if different to yours:*	**Child name:** **Child DOB:** **Child Address** *if different to yours:*
Do you have any caring responsibilities?	Yes/No	

MEDICAL HISTORY	
Personal medical history: *(Please circle)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems Heart Conditions Asthma Diabetes Contact with Tuberculosis Infectious Diseases	**Any further comments:**

Cancer Mental Health Other (Please specify)			
Family medical history: *(Please circle and specify who in further comments)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems **Family History –Continued:** Heart Conditions Asthma Diabetes Contact with Tuberculosis Infectious Disease Cancer Mental Health Other (Please specify)	**Any further comments:**		
Do you smoke? *(Please circle)*	Yes No If yes how many smoked per day.....	**Do you use drugs?** *(Please circle)*	Yes No
Alcohol Consumption *Please add number of units*	____ Units Per Week		

per week	

CURRENT MEDICATION *(Please list)*	
Health Condition	**Medication Required**