FOWEY RIVER PRACTICE

New Patient Questionnaire

Your Contact Details:

Title: Surname:

Date of Birth: First Names:

Occupation: Previous Surnames:

Home Address: Home Telephone:

Work Telephone:

Postcode: Mobile Telephone:

If you would like to use our on-line facilities please complete a consent form and return it in person with valid photo ID or your passport

Proof of identity and address provided:

☐ Birth Certificate ☐ Driving Licence ☐ Passport ☐ Utility Bill

☐ Allowance Book ☐ Solicitor's Letter ☐ Offer of Tenancy ☐ Other (please specify)

Information about you:

What is your height?

What is your weight?

What is your first language?

Do you need an interpreter? Yes ☐ No ☐

Have you ever had/suffered from? (Tick as appropriate)

☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ HRT	☐ Stroke
☐ On Warfarin	☐ COPD
☐ Emphysema	☐ Asthma
☐ Cancer	☐ Learning Disability
☐ Epilepsy	☐ Depression
☐ Contraception	

PTO

Female History:

Date of your last smear:

Date of your last mammogram:

Date of Implanon/Coil insertion:

Any relevant family history

List of your current medication

Smoking:

☐ Never smoked
☐ Current smoker – number of cigarettes/cigars per day:
☐ I would like advice on giving up
☐ No I do not wish to give up
☐ Ex-smoker – number of cigarettes/cigars per day: Date stopped:
If you would like to give up smoking, please book an appointment with our Stop Smoking Adviser, Leanne Smith

Alcohol:

	0	1	2	3	4	Score
How often do you have a drink that contains alcohol? (circle the answer that best describes your drinking habit)	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	