Park Side Medical Practice

Park View Centre, Chester Road North, Brownhills, WS8 7JB
Tel No 01543 728748 ***Dr D Jay***
Fax No 01543 377741

NEW PATIENT QUESTIONAIRE
All Information provided is confidential.

We ask you to **FULLY** complete this form to ensure we have accurate details about your health prior to receiving your medical records from your previous GP.

Surname: **Forename:**	**Date of Birth:**
Address:	**Telephone No(s):**
NHS number (If known):	**Main Language Spoken:**
Email Address: **(By providing your email address, you are giving consent to receive emails from the practice)**	
Ethnicity: **White/British ☐ Black/British ☐ British/Asian ☐ Mixed British ☐** **Other Ethnic Group ☐ Please State:**	

Will you require access to our online appointment / prescription service? YES/ NO

Would you like to receive information or would like to join our Patient Participation Group? YES/NO

Meetings are held on a quarterly basis or you could become a virtual member

Carer: If you have a carer in place please state name address and telephone number.

If you are a carer please state here.

Medical History: Please list any serious illness, operations, ongoing problems & disabilities
Medication: Please list all regular medication including herbal remedies: **Allergies:**

Have you ever had a TB vaccination (circle your answer)? YES - Approx When?	NO
Height:	**Weight:**

Do you Smoke? YES ☐ NO ☐ If yes, would you like help to quit? YES ☐
How many units of alcohol do you drink per week? **1 unit = ½ pint of beer/lager/cider,1 small glass of wine, 1 small measure of spirits**
Exercise **Activity Level: Poor ☐ Moderate ☐ Fairly Active ☐ Very Active ☐**

Family History:			
High Blood pressure	YES/NO	Glaucoma	YES/NO
Heart Disease	YES/NO	Thrombosis	YES/NO
Stroke	YES/NO	Asthma	YES/NO
High cholesterol	YES/NO	Diabetes	YES/NO
Other: (Please state)			
For Women only:			
Number of pregnancies			
Have you ever had a cervical smear? YES / NO If yes date of last smear:			
Have you ever had an abnormal smear: YES / NO			