

Wellington Medical Centre New Patient Questionnaire

PERSONAL DETAILS	
Title	
Surname	
First Names	
Date of Birth	
Place of Birth	
Address	
Post Code	
Home Telephone No.	
Mobile Telephone No.	
E-mail address	
Status	Single - Married - Divorced - Widowed Cohabiting - Separated - Other
Occupation	

SMOKING	Please tick one option below
Are you a smoker?	Never smoked
	Ex smoker (please say when you gave up)
	Current smoker
	Refused to say

MEDICAL HISTORY

Past illnesses and operations

Current medical conditions

Current medical treatments (drugs including dosage)

Known allergies

Date of last tetanus injection (if known)

Date of last cervical smear (if applicable)

FAMILY HISTORY

Parents (age and state of health)

Children (sex, age and state of health)

Brothers/sisters (age and state of health)

NHS - SUMMARY CARE RECORD

Wellington Medical Centre is a NHS Summary Care Record Site
Please state whether you wish to have a Summary Care Record Created for you.

Further information leaflet's are available inside your New Patient Pack,
or alternatively you can visit www.nhscarerecords.nhs.uk or call the
NHS Care Records Service Information Line on ☎ 0845 603 8510 for further information

YES

NO

ALCOHOL Please tick one option for each question	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	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	Less than monthly	Monthly	Weekly	Daily or almost daily	

CARING	
Are you a carer?	Yes / No
If yes who do you care for: Name Relationship Contact telephone number	
Do you have a carer?	Yes / No
If yes who is your carer: Name Relationship Contact telephone number	
Carer Support Worker's are available through the Medical Centre, would you like someone to contact you?	Yes / No

FIRST LANGUAGE	
What is your First Language?	

ETHNICITY	
What do you consider your ethnic origin to be?	Please tick one option below
WHITE	
British	
Irish	
Any other white background (Please specify)	
MIXED	
White & Black Caribbean	
White & Black African	
White & Asian	
Any other mixed background (Please specify)	
ASIAN OR ASIAN BRITISH	
Indian	
Pakistani	
Bangladeshi	
Any other Asian background (Please specify)	
BLACK OR BLACK BRITISH	
Caribbean	
African	
Any other black background (Please Specify)	
CHINESE OR OTHER ETHNIC GROUP	
Chinese	
ANY OTHER (Please specify)	
DECLINED TO SAY	

Thank you for completing this questionnaire

Please return this form to reception