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New Patient Form

COURTYARD SURGERY
Tel :01380 813300
reception.courtyard@nhs.net

NP appointment:
ID verified:

Welcome to Courtyard Surgery

Please could you complete this questionnaire to help us until we receive your records from your previous surgery.

PLEASE USE BLOCK LETTERS

Mr/Mrs/Miss/Ms/ Other Surname:

Forenames : "Known as" :

DOB: Previous Surname:.....

Address

Postcode Tel No:(Day)(Eve)

Which number may we leave messages on? (delete as appropriate) Landline / Mobile

Email:.....

Occupation

Next Of Kin: Name Relationship:.....

Tel No:

(FOR UNDER 16'S)

Parent/Guardian.....Tel No:.....

School attending

ALL PATIENTS

Please state below, as briefly as possible, any significant illnesses, accidents and operations that you have had; if recent, please give dates and hospitals if known:-

.....

.....

Are you on any medication? (Please state)

.....

Have you any allergies? (Please state)

Do you smoke? Never [] Used to [] How many per day ?

Currently [] How many per day?

Do you drink alcohol? Never [] Yes [] How much per week?

Are you a carer or cared for? Yes – I am a carer [] Yes - I am cared for [] No []

(If yes, please ask at Reception to sign onto our carer's register)

P.T.O.

Females only:-

Have you ever had a smear? Date of last smear test

Do you use contraceptives? Please state which kind

Have you had a hysterectomy? Please state month and year

How many children have you? Please give dates of birth

Have you had any miscarriages? Did you have normal deliveries

All Patients:-

Have you or your family or close relatives had any of the following illnesses or conditions?:-

	You	Family (Please state relationship)
Sugar diabetes	Yes/No .....	.....
Asthma	Yes/No .....	.....
High Blood Pressure	Yes/No .....	.....
Stroke	Yes/No .....	.....
Epilepsy or fits	Yes/No .....	.....
Skin diseases	Yes/No .....	.....
Cancer/leukaemia	Yes/No .....	.....
Kidney disease	Yes/No .....	.....
Glaucoma	Yes/No .....	.....
Other disease	Yes/No .....	.....
Please give details	.....	.....
Depression/other Mental health problems	Yes/No .....	.....

Have you ever suffered from/ever had?

High cholesterol	[]	Irregular heart rate	[]
Angina	[]	Blocked leg arteries	[]
Heart Failure	[]	Heart surgery	[]

DO YOU HAVE ANY COMMUNICATION DIFFICULTIES? Please tick as appropriate:

I might need LARGE PRINT [] HEARING LOOP [] LANGUAGE TRANSLATION []

by

Other

DATE FORM COMPLETED:

WHERE DID YOU HEAR ABOUT COURTYARD SURGERY?