THE GLENLYN MEDICAL CENTRE NEW PATIENT QUESTIONNAIRE

Please complete both pages

All patients at this practice have a Named GP who is responsible for their overall care at the practice. If you have a preference as to which clinician is your Named GP, we will make reasonable efforts to accommodate your request.

You may request an appointment with any of the clinicians.

YOUR NAMED GP IS

YOUR CONTACT DETAILS

SURNAME

GIVEN NAME

ADDRESS

HOME TEL NO:

TODAY'S DATE

DATE OF BIRTH

OCCUPATION

NEXT OF KIN'S NAME

WORK TEL NO:

MOBILE TEL NO:

PERSONAL MEDICAL HISTORY

State significant illness / operations with dates:

MEDICATIONS

Name of drug	Strength	Frequency

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINE? YES or NO

IF SO, WHICH ONES:

WEIGHT

HEIGHT

BLOOD PRESSURE

URINALYSIS

ALCOHOL UNITS PER WEEK

DIET Normal / Average / Poor

Special diet:

SMOKER YES or NO

IF No:-

Never smoked tobacco

Currently a non smoker

IF Yes:- YES or NO

Would you like to talk to our smoking cessation advisor?

EXERCISE:

Light

Moderate

Heavy

Other:

FAMILY HISTORY

HEART DISEASE	YES or NO	FAMILY MEMBER
	Under 60	Over 60
STROKE	YES or NO	FAMILY MEMBER
DIABETES	YES or NO	FAMILY MEMBER
ASTHMA	YES or NO	FAMILY MEMBER

ACCESSIBLE INFORMATION - DO YOU HAVE ANY COMMUNICATION NEEDS?

Please let us know if, for example, you use lipreading, need an interpreter, need large print or Easy Read format etc:

ARE YOU A CARER OR DO YOU HAVE A CARER? ***YES or NO***

If yes, please complete the carer's registration details below:

CARER'S REGISTRATION DETAILS		
SEX	M/F	HOUSE NAME/FLAT
SURNAME		NO & STREET
FORENAME		TOWN
DOB		POSTCODE
TITLE		TELEPHONE
NAME OF CLIENT		REGISTERED DOCTOR (if at Glenlyn)
DOB OF CLIENT		RESPONSIBLE AUTHORITY
CLIENT'S GP (if at Glenlyn)		DATE OF PERMISSION GIVEN TO CARE FOR PATIENT
I would like to be added to the Carer Support Elmbridge Mailing List		

ANYTHING ELSE WE SHOULD KNOW?

Medical notes can take some time to arrive so please let us know if there is anything else we should be aware of e.g. Power of Attorney, or a signed instruction regarding end of life care. If you wish to give consent for your medical care to be discussed with another person or persons, please give their name and sign and date.

ETHNICITY FORM - STRICTLY CONFIDENTIAL

White

- British ☐
- Irish ☐
- Any other White background ☐

Black or Black British

- Caribbean ☐
- African ☐
- Any other Black background ☐

Mixed

- White & Black Caribbean ☐
- White & Black African ☐
- White & Asian mixed ☐
- Any other mixed background ☐

Asian or Asian British

- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Any other Asian background ☐

Other Ethnic Groups

- Chinese
- Any other ethnic group ☐

(Please specify)

I prefer not to answer ☐

FIRST LANGUAGE

- English ☐
- Bengali & Sylheti ☐
- Cantonese ☐
- Polish ☐
- Other ☐

(Please specify)