

## **New Patient Questionnaire**

Patient Name:					
Gender (please circle): Female/ Male/ Non-binary/ Not Specified					
Ethnicity (please circle): White/Black Caribbean/Black African/Black Other/					
Black Mixed/ Indian/ Pakistani/ Bangladeshi/ Chinese/ Other Non-Mixed/					
Other-Mixed/ Prefer not to say  Makila Tal Na					
Tel No:Mobile Tel No:					
If registering a new baby, Name of Mother:					
Email Address:					
If you do not speak English please tell us your preferred language/ how you would like us to communicate with you:					
Welsh □ BSL □ Other- please specify					
Are you a Military Veteran/ served in the Armed Forces: No $\square$ Yes $\square$					
Have you been registered here previously: No $\square$ Yes $\square$					

Are you moving in/living with anyone who is already registered here?

Allergies:				
Allergies.				
Weight:	Height	Height:		
Visit www.nhs.uk/live-well				
Alcohol:		Smoking Status:		
Units/wk	□ E>	☐ Ex-Smoker / Date Stopped		
The Doctors in this practice advise that to keep the risk from alcohol low, adults should not regularly drink more than 14 units of alcohol per week.  DAN24/7 HELPLINE on 0808 808 2234		The Doctors in this practice <u>Do Not</u> recommend smoking. If you would like assistance to stop smoking or for further information please contact the  HELP ME QUIT HELPLINE		
Do you look after anyone as an		arer? No □	<b>085 2219</b> Yes □	
11 yes, then name				
Are you on repeat medication? Yes Please provide us with surgery When we receive your notes fr medical history. Provide detail Family History/ Past Medical H	a repeator om your Is here if	previous GP we wi you would like to t	ll summarise your	