NEW PATIENT INFORMATION CARD

DATE
SURNAME
FIRST NAME (S)
FULL ADDRESS
Email:
TEL.NO. HOME OCCUPATION
MARITAL STATUS DATE OF BIRTH
RELIGIONETHINICITY
COUNTRY OF ORIGINSEX
IS YOUR MAIN LANGUAGE ENGLISH (Y / N) IF NO WHAT?
DO YOU NEED INTERPRETOR, IF YES WHAT LANGUAGE?
ARE YOU A CARER (YES/NO) Please sign the Carer Consent form
DO YOU HAVE A CARER (YES/NO). Please provide details
Name
GENERAL HISTORY
Have you had any serious illness or operations, X-rays or similar tests and when?
What medicines are you taking?
Have you any allergies to medicines or anything else?
How much tobacco or cigarettes do you smoke per day?
Do you have any communication need? (Y/N)(If YES, PLEASE FILL THE ACCESSIBLE INFORMATION FORM)

Questions	Scoring system					Your
	0	1	2	3	4	score
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per day	3-4 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often have you had 6 or more units if female or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	monthly	weekly	Daily or almost daily	

FAMILY HISTORY

Which of y	our blood relation	ns have suffered	d from the follo	wing?				
Heart Atta	nck 🗆		Cancer	□				
Diabetes	□		High BP	□				
Asthma	□		Tubercul	osis 🗆				
Stroke	□		Other seri	ous Illness 🗆				
VACCINATIONS which vaccination have you had and when?								
Diphtheria	ı 🗆	•••••	Polio 🗆					
Tetanus	□		MMR \square					
FOR FEMALE PATIENT ONLY								
Have you had children? () Give ages								
Have you had hysterectomy? () Date								
Which method of contraception are you using at present? Have you had your smear test?								
DO NOT COMPLETE THIS SECTION								
Date								
Urine E		Glucose weight		lbumineight				