CITY WALLS MEDICAL CENTRE/SAUGHALL MEDICAL CENTRE
PATIENT QUESTIONNAIRE

PERSONAL DETAILS **Date: / /**

Title: Mr / Mrs / Ms / Other: ………... Surname: …………………………. First Name(s): ……………………

Date of Birth: / / Marital Status: ……………………. Occupation: ………………………

Address: ………………………………………………… ………………………………………………… Previous Address: ……………………………………………….. ………………………………………………..

Post Code: ………………………………………………… Post Code: …………………………………………………

Telephone: ………………………………………………… Mobile: ……………………………………………………

Place of Birth: …………………………………………… Country of Origin: ………………………………………

Previous Practice in UK and reason for change: ……………………………………………………………………...

………

ETHNIC ORIGIN

White:	British	☐	Irish	☐		
	Other White Background (please specify): ……………………………………………					
Mixed:	White / Black Caribbean	☐	White / Black African	☐	White / Asian	☐
	Other Mixed Background (please specify): ……………………………………………...					
Black:	British	☐	Caribbean	☐	African	☐
	Other Black Background (please specify): ……………………………………………					
Asian or Asian British:	British	☐	Irish	☐		
	Other White Background (please specify): ……………………………………………					
Other Unlisted:	Other (please specify): ……………………………………………………………….					

Main Spoken Language: …………………………….

NEXT OF KIN

Name: …………………………………………………. Relationship: ……………………………………………

Telephone: …………………………………………… Mobile: ……………………………………………………

PERSONAL MEDICAL AND SOCIAL HISTORY

Are you allergic to anything? Yes / No

Drugs: ……………………………………………………

Other: …………………………………………………….

Do you smoke?				
	Yes	☐	What do you smoke?	Cigarettes ☐ Cigars ☐ Pipe ☐
			How much do you smoke each day?	……………cigarettes/oz
	Ex-Smoker	☐	When did you stop? …………………………………………………	
	Never Smoked	☐		

PTO

Do you exercise each week?	Impossible ☐ None ☐ Light ☐	Moderate ☐ Strenuous ☐ Athlete ☐
Are you a carer? (Do you care for a family member of friend?)	Yes ☐	Relationship to person: ……………………………… Are they registered at City Walls? Yes / No
	No ☐	
Do you have a carer?	Yes ☐	Carer's Name: ……………………………………… Telephone: …………………………………………….
	No ☐	

Do you suffer from or have a history of:

Heart Attack / Angina	☐	Stroke	☐	Diabetes	☐		
Asthma / COPD	☐	Thyroid Problems	☐	Blood Pressure	☐		
Mental Illness	☐	Glaucoma	☐	Cancer	☐	Epilepsy	☐

Do you consider yourself to have a disability that we need to be aware of to ensure all your needs are met when you visit the practice?

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FAMILY HISTORY

Has any close relative (brother, sister, parent) suffered from: (please also specify who)

Heart Attack	☐	Heart Disease before age 60	☐	Heart Disease after age 60	☐
Stroke	☐	Breast Cancer	☐	Asthma	☐
Diabetes	☐	High Blood Pressure	☐	Raised Cholesterol	☐

FEMALE PATIENTS ONLY

Do you have either of these methods of contraception fitted?

Mirena Coil ☐ Ring Pessary ☐

Approximately which month and year was it fitted? ………………………

If not, what form of contraception (if any) do you use? …………………………………………………………

When was your last smear? ……………………………………………………………………………………..

As a practice, we recommend you take regular exercise (e.g. cycling, swimming, aerobics, resistance training) 3 times per week, along with a sensible balanced diet.
We also recommend you have regular blood pressure check. Please attend yearly for this.
Smokers are strongly advised to stop.

STAFF ONLY TO COMPLETE

Photo ID

- Passport ☐
- I.D. Card ☐
- Driver's License ☐

Other (please specify) ……………………………………………………………………

Verified By: ……………………………………… Signature: ………………………………………..