

**Vesta Road Surgery  
New Patients Questionnaire**

Date:-

First Name .....

Family Name .....

Date of Birth .././....

Occupation .....

Ethnic Status .....

Next of kin .....

She/he is my .....

**Are you a carer?**

Do you help a friend or relative to live their daily life?

Yes/No

**Are you cared for?**

Do you have a friend or relative who helps you live your daily life?

Yes/No

What do you consider to be your National Identity?

.....

What is your country of birth? .....

What is your main spoken language? .....

What language do you prefer to read? .....

I need an Interpreter or translator? Yes/No

I can read English Yes/No

Do you need large print? Yes/No

Do you use lip reading? Yes/No

Do you use Textphone/Minicom? Yes/No

Do you rely on British Sign Language? Yes/No

Please Continue Overleaf

I do not read ANY language and someone helped me to fill in this form Yes/No

What is your religion? Please write in or tick the box if the question does not apply to you.

Religion ..... Religion None

**General Information**

What is your:- Height? ..... Weight? .....

What is your sickle cell status, if known? .....

When was your last tetanus injection? .....  
Poliodrops/vaccinations?

Do you smoke?

If yes, how many a day? .....

If no, have you ever smoked Yes/No

Do you take at least half an hour's exercise every week?  
(This can include walking, doing housework, have a job that requires physical work, gardening, football, etc)

Yes/No

Do you do 20 minutes of exercise 3 times a week?

Yes/No

**Information about your past health**

Please list any major illnesses, injuries or operations you may have had in the past

Have you had?

a) heart disease b) stroke c) mini stroke Yes/No

If yes please give details

.....

Please Continue Overleaf

Do you have asthma? Yes/No

Have you ever had psychiatric problems? Yes/No  
 If yes please give details .....

Are you currently attending hospital? Yes/No

Are you receiving any medical treatment  
 or drugs at present? Yes/No  
 Please give details .....

Are you allergic to any drugs or  
 do you have any other allergies? Yes/No  
 Please state which .....

**Information about family health**

Does or has any member of your family had any of the following? If yes, please note which relative – e.g. Brother, Grandmother.

Also, for heart disease only, if known (even approximately) their age when they first suffered the problem:

Heart Disease  
 .....

Age of onset .....

- Asthma .....
- Stroke .....
- High blood pressure .....
- Cancer (what type, what of) .....
- Diabetes .....
- Other (what?) .....

**For Women**

Have you had a cervical smear? Yes/No

What is the date of your last smear? .....

Where did you have the smear?

Doctor's surgery/Family planning clinic/Privately

(Please delete those which do not apply)

What was the result?

Have you ever had any abnormal smears? Yes/No

If yes, give details .....

Are you using contraception? Yes/No

If so what method .....

How many children have you had? .....

How many pregnancies have you had? .....

Have you had a hysterectomy? Yes/No

Are you on HRT? Yes/No

Have you had breast screening? Yes/No

What was the date of your last Mammogram?

.....

Have you had any abnormal results? Yes/No

If yes, give details .....

Please complete next form

Thank you for your time.