

# MILTON SURGERY

## New Patient Confidential Health Questionnaire

|  |          |
|--|----------|
| Title (e.g. Mr/Mrs/Miss/Ms/Other)  |          |
| Forename/s   |          |
| Surname  |          |
| Date of Birth (DD/MM/YYYY)   |          |
| Address  |          |
| City   |          |
| Postcode   |          |
| Mobile Number  |          |
| Landline Number  |          |
| Email  |          |
| Do you consent to receiving text messages from the surgery e.g. appointment reminders? | YES / NO |
| Do you consent to online prescriptions?  | YES / NO |
| Gender at birth  |          |
| Current gender   |          |
| What do you like to be known as?   |          |
| Preferred pharmacy   |          |
| Emergency Contact / Next of Kin  |          |
| Emergency Contact / NOK Address  |          |
| Emergency Contact / NOK Telephone Number   |          |
| Do you care for someone?   | YES / NO |

|  |      |
|--|------|
| Name and DOB of all patients at same address (continue on back page if required) |      |
| Name:  | DOB: |

**Medical Problems** - Please list any medical problems you may have, have had or any operations (continue on back page if required):

| Date diagnosed / date of operation | Medical Problem / Operation |
|------------------------------------|-----------------------------|
|                                    |                             |
|                                    |                             |
|                                    |                             |
|                                    |                             |

**Have you had a blood transfusion or received an organ donation before 1996? (please circle)** YES / NO

**Personal / Family History - Please circle if you, or a member of your family have any of the following:**

| Personal                            |          | Family                              |          |
|-------------------------------------|----------|-------------------------------------|----------|
| Heart Disease (angina/heart attack) | YES / NO | Heart Disease (angina/heart attack) | YES / NO |
| High Blood Pressure                 | YES / NO | High Blood Pressure                 | YES / NO |
| Asthma                              | YES / NO | Asthma                              | YES / NO |
| Other respiratory Disorder          | YES / NO | Other respiratory Disorder          | YES / NO |
| GI/Liver Disease                    | YES / NO | GI/Liver Disease                    | YES / NO |
| Diabetes                            | YES / NO | Diabetes                            | YES / NO |
| Epilepsy                            | YES / NO | Epilepsy                            | YES / NO |
| If yes, when was last seizure?      |          | Thyroid Disease                     | YES / NO |
| Thyroid Disease                     | YES / NO | Psychiatric Disorder                | YES / NO |
| Psychiatric Disorder                | YES / NO | Infectious Disease                  | YES / NO |
| Infectious Disease                  | YES / NO | Stroke                              | YES / NO |
| Stroke                              | YES / NO | Arthritis                           | YES / NO |
| Arthritis                           | YES / NO | Cancer                              | YES / NO |
| Cancer                              | YES / NO |                                     |          |
| Surgical Operations                 | YES / NO |                                     |          |

**Cervical Screening History - If you had your smear out with the UK please provide evidence of this and bring it along with this form when you come in to register. If you are unable to provide this please let us know in the 'any other comments?' section:**

|                               |  |
|-------------------------------|--|
| Date of last smear            |  |
| Country where smear was taken |  |
| Result and recall advice      |  |
| Any other comments?           |  |

**Height & Weight**

|                       |  |     |
|-----------------------|--|-----|
| Height in centimetres |  | cms |
| Weight in kilograms   |  | kgs |

**Allergies - Do you have any allergies? If yes please list below (continue on back page if required):**

| Allergy | Severity (Please circle) |
|---------|--------------------------|
|         | Mild / Moderate / Severe |
|         | Mild / Moderate / Severe |
|         | Mild / Moderate / Severe |

**Smoking /Electronic Cigarette (e.g. Vapes)**

|                                      |          |
|--------------------------------------|----------|
| Do you smoke?                        | YES / NO |
| Have you ever smoked?                | YES / NO |
| If you are a smoker, how many a day? |          |
| Do you use electronic cigarettes?    | YES / NO |
| If yes, how often?                   |          |

