SOUTHBROOM SURGERY
New Patient Information

Welcome to Southbroom Surgery.
Our aim is to provide new patients with the most appropriate care. It can take a few weeks to receive your medical records so please you could complete the following questions and return with all forms to the surgery.

Full Name: …….. Date of Birth: ……..

Address:……..……Postcode:……

Home Tel No:…….. Mobile:…… Work:……..

Previous GP: ……Surgery:……..

Ethnic Origin:…… First Language :……

Please select **Y**es or **N**o for the following questions:

Y	**N**	Are you registered Blind	**Y**	**N**	Are you registered Deaf
Y	**N**	Are you registered Partially Sighted	**Y**	**N**	Are you registered Partially Deaf
Y	**N**	Do you have any other disability			

Smoking Status **Never Smoked** **Smoker** **Ex- Smoker (month/year) …….. /……..**
You stopped

Would you like to stop smoking? **YES / NO**

Have you ever had any serious illnesses, or been in hospital? **YES / NO**
Please state what_____

Have you ever been diagnosed with any of the following illnesses? Please Circle below

Asthma	**Diabetes**	**Mental Health**	**Renal Failure**	**Chronic**
Epilepsy	**Heart Disease**	**Depression**	**Dementia**	**Obstructive**
Cancer	**High Blood**	**Hypothyroidism**	**Stroke**	**Pulmonary**
	Pressure			**Disease**

Please supply details below of any other illnesses that you receive regular treatment for?

Have any close members of your family had? **Heart Disease Stroke Diabetes**

_____

Have you ever served in the **Army / Navy / Air Force**

Current Height – cm/ft		Current Weight – kg/stone	

Please list all medication you are currently taking: (including the contraceptive pill)?

Name of Medication	Strength of Medication	Dose of Medication

Do you have any allergies?

Y	**N**	
Y	**N**	

Additional Information – Please tick any of the following or enter information you feel will help us whilst we await your medical records to arrive.

Are you a Carer?		**Do you have a Carer?**		**Do you use a wheelchair?**	
Do you live with your Carer?		**Do you need help with daily tasks?**		**Do you need help taking medication?**	
Are you pregnant? **Due Date……**		**Would you like to receive SMS text Messages**	**Y** **N**	**Are you interested in Online Services**	**Y** **N**

THIS INFORMATION IS FOR THE SURGERY USE

Patient Signature: …… Date of Completion: ……..

Thank you for taking the time to complete this questionnaire. Please hand this in at reception and ask about online registration for booking appointments, repeat prescription service, online messaging and emailing.