OFFICE USE ONLY (please tick)
2 Proofs of Address seen:…….
1 Proof Of ID seen:……..
Previous Address Filled in:……
Previous GP Filled in:……..
Place Of Birth:……..
If not UK-Date of Entry:……..
Signed and Dated by pt:……..
Alcohol Questionnaire:……..
RECEPTIONISTS' INNITIALS: ……

NEW PATIENT QUESTIONNAIRE

Thank you for registering as a patient of Valentine Health Partnership. Could you please complete this form and return it to the receptionist with your registration documents.

Name: **DOB:**

Address:

E-mail address:

Height: cm **Weight**: kgs

Latent TB Screening:

i. *Country of Birth:*
ii. *Have you been tested or treated for TB in the UK? YES ☐ NO ☐*
iii. ***Are you aged between 16-35?*** *If yes, have you lived in one of the countries below for a period of 6 months or more in the last 5 years:*
(Please tick as appropriate):

Afghanistan ☐	Greenland ☐	Macedonia ☐	Nigeria ☐	Somalia ☐
Bangladesh ☐	Guyana ☐	Micronesia ☐	North Korea ☐	East Timor ☐
Bhutan ☐	Haiti ☐	Moldova ☐	Pakistan ☐	Uganda ☐
Cambodia ☐	India ☐	Mongolia ☐	Papua New Guinea ☐	Vietnam ☐
Georgia ☐	Indonesia ☐	Myanmar/Burma ☐	Philippines ☐	Any other African country (please specify) ☐ ……
Ghana ☐	Laos ☐	Nepal ☐	Sierra Leone ☐	

Smoking *(please tick one of the following):*

Never smoked tobacco	☐	Stopped smoking	☐ *date:*
Passive smoker	☐	Cigarette smoker	☐ *amount per day:*
Pipe smoker	☐	Roll own cigarettes	☐ *amount per day:*
Chews tobacco	☐	Cigar smoker	☐ *amount per day:*

Trying to give up smoking YES/NO
On Nicotine replacement therapy YES/NO
Would you like an appointment with a smoking cessation advisor? YES/NO

Alcohol: (to be completed by 16+ year olds)

How many units do you drink per week *(1 unit = ½ pint/one measure of spirit)* ……units
Please also complete the **AUDIT C questionnaire** (attached)

PLEASE TURN OVER

Personal History: Do you suffer from any of the following conditions: *(if YES please give approx date of onset)*

Asthma	YES/NO	Diabetes	YES/NO
Heart Disease	YES/NO	Hypertension	YES/NO
Hypothyroidism	YES/NO	Epilepsy	YES/NO
COPD	YES/NO	Stroke/TIA	YES/NO
Heart Failure	YES/NO	Chronic Kidney Disease	YES/NO

Cancer – please specify: ……
Any operation – please specify:……
Are you taking regular medication? YES/NO
Please specify…..

If you have answered YES to any of the above, please ask receptionist to make you an appointment with the relevant Healthcare Professional. Please bring a list of your repeat medication with you to your appointment.

Allergies
Do you suffer from any allergies YES/NO
(if YES please specify)…..

Family History
Does/has anyone in your family suffer/suffered from any of the following:

Heart Disease (aged under 60) YES/NO *If yes – who…….*
Heart Disease (aged over 60) YES/NO *If yes – who…….*
CVA/Stroke YES/NO *If yes – who…….*
Diabetes YES/NO *If yes – who…….*
Asthma YES/NO *If yes – who…….*
Cancer YES/NO *If yes – who…….*

Next of Kin
Name: Relationship: Telephone:

Main Spoken Language
What is your main spoken language? Do you require an interpreter? YES/NO

Ethnic Category – 2001 Census: Please tick next to the ethnic category that best describes you

White British	
British/mixed B**ritish**	Please Specify:
Irish	
Other White	Please specify:
White & Black Caribbean	
White & Black African	
White & Asian	
Other Mixed	
Indian	
Pakistani	
Bangladeshi	
Other Asian	Please Specify:
Caribbean	Please specify:
African	Please Specify:
Other Black	Please Specify:
Chinese	
Other	Please Specify:
Not Stated	

Signed: Date: