

**Fremington Medical Centre
New Patient Questionnaire**

Name: _____

Address: _____

Date of Birth: _____

Contact telephone number (if possible, include a mobile number):

Email address: _____

Nationality: _____

First Language: eg English _____

Occupation: _____

Allergies: _____

Current Medication: _____

Current Medical Problems: _____

Previous operations/significant illnesses:

Smoking Status

Do you smoke? YES / NO
Have you ever smoked? YES / NO
If Yes, when did you give up? _____

Cigarette smoker (number per day) _____

Rolls own cigarettes (ounces per week) _____

Cigar smoker (number per day) _____

Pipe smoker (ounces per day) _____

Family History

Heart disease under 60 yrs old, if yes, who?

Heart disease over 60 yrs old, if yes, who?

Diabetes

Stroke

High Blood Pressure

High Cholesterol

Cancers

Others (please specify)

Are you a carer? YES / NO
If yes, what is your relationship to the person you care for? eg wife, friend, etc

How much exercise do you do?

Are you on a special diet?

Please circle your answers to the following three questions:

How often do you have a drink that contains Alcohol?

Never / Monthly or less / 2-4 times per month
2-3 times per week / 4+ times per week


How many standard alcoholic drinks you do you have on a typical day when you are drinking?

1-2 / 3-4 / 5-6 / 7-8 / 10+

How often do you have 6 or more standard drinks on one occasion?

Never / Monthly or less / Monthly / Weekly/
Daily or almost daily

PLEASE BRING A SAMPLE OF URINE
TO YOUR NEW PATIENT MEDICAL
APPOINTMENT. A BOTTLE IS AVAILABLE
FROM RECEPTION

Please turn over 

**Fremington Medical Centre
New Patient Questionnaire**

ETHNIC CATEGORY AND FIRST LANGUAGE

We are now required to collect ethnicity information and first language details for all our patients when registering in the Practice. Please indicate your ethnicity group and first language from the options below. If you do not wish to state your ethnicity group, please tick the last box. Please return this form with your registration form to reception.

ETHNICITY

British/mixed white		Bangladeshi/British Bangladeshi	
Irish		Other Asian	
Other white		Caribbean	
White and black Caribbean		African	
White and black African		Other black	
White and Asian		Chinese	
Other mixed		Other	
Indian/British Indian		Ethnic category not stated	
Pakistani/British Pakistani			

LANGUAGE

English		Hebrew		Turkish	
British Signing Language		Hindi		Urdu	
Welsh		Igbo (Ibo)		Vietnamese	
French		Japanese		Yoruba	
German		Korean		Other	
Italian		Kurdish			
Spanish		Lingala			
Cantonese		Luganda			
Dutch		Makaton (sign language)			
Gaelic		Malayalam			
Greek		Mandarin			
Polish		Norwegian			
Akan (Ashanti)		Pashto			
Albanian		Patois			
Amharic		Portuguese			
Bengali & Sylheti		Punjabi			
Brawa & Somali		Russian			
Cantonese or Vietnamese		Serbian/Croatian			
Creole		Sinhala			
Ethiopian		Somali			
Farsi (Persian)		Swahili			
Finnish		Swedish			
Flemish		Wylheti			
French Creole		Tagalog (Filipino)			
Gujarati		Tamil			
Hakka		Thai			
Hausa		Tigrinya			

PLEASE RETURN THIS FORM TO THE SURGERY ALONG WITH YOUR REGISTRATION FORM. MANY THANKS