NEW PATIENT CONFIDENTIAL QUESTIONNAIRE

Welcome to Stowhealth.
Please complete this confidential questionnaire, which will help the Doctors and Nurses at Stowhealth appreciate your health needs.
This form is also available on our web site www.stowhealth.com

PERSONAL DETAILS

First Name:
(in CAPITALS please)

Middle Name
(in CAPITALS please)

Surname:
(in CAPITALS please)

Previous Surname:
(in CAPITALS please)

Home Address:

Town:

Postcode:

Home Tel No:

Daytime Tel No:

Mobile No:
It is now possible for Stowhealth to send you text messages of relevant information to your mobile, such as appointment reminders and health campaigns. Please confirm you are happy for us to contact you in this way: Yes ☐ No ☐

E-Mail address:
Do you wish us to communicate with you as an individual via e-mail where possible in the future? Yes ☐ No ☐

Date of Birth: Place of Birth: Male or Female? M / F

Occupation:

Single / Married / Divorced / Separated / Remarried / Widowed / Living with partner

Children (please list names and ages)

	Age		**Age**
1.		2.	
3.		4.	
5.		6.	

ETHNIC ORIGIN

What groups do you mostly identify with? *Please tick only ONE box in Section A and ONE box in Section B.*

Section A

- ☐ British or Mixed British
- ☐ English
- ☐ Irish
- ☐ Scottish
- ☐ Welsh
- ☐ Other *(please specify)* _____

Section B

ASIAN
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Other (*please specify*)

_____

BLACK
- ☐ African
- ☐ Caribbean
- ☐ Other (*please specify*)

CHINESE
- ☐ Any (*please specify*)

_____

MIXED ETHNIC BACKGROUND
- ☐ Asian and White
- ☐ Black African and White
- ☐ Black Caribbean and White
- ☐ Other (*please specify*)

WHITE
- ☐ Any (*please specify*)

_____

OTHER BACKGROUND
- ☐ Other (*please specify*)

_____

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TOTAL HEALTH

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ALLERGIES

Has a doctor told you that you are allergic to latex? Yes ☐ No ☐

If yes, what type of reaction do you have? _____

Do you have any other allergies or reactions to anything else?

Allergy	**Reaction**

MEDICAL HISTORY

Previous Doctor's Name & Address:

Previous illnesses / operations / hospital admissions (with dates and your age at the time)

Immunisations – Have you had the following vaccinations and if so, when?

Tetanus Yes ☐ No ☐ **Oral Polio** Yes ☐ No ☐ **Rubella (females)** Yes ☐ No ☐

MMR Yes ☐ No ☐

CURRENT MEDICAL DETAILS

Do you have any **current** health problems? Yes ☐ (please list) No ☐

Please list any medication you take, including those bought over the counter?

Do you know what each medication you take is for? Yes ☐ No ☐

If not, would you find it helpful to have the reason on label? Yes ☐ No ☐

ADDITIONAL MEDICAL INFORMATION

Do you smoke? Yes ☐ No ☐ If YES, how many per day? _____

Have you smoked before? Yes ☐ No ☐ If YES, when did you stop? _____

Would you like help or advice about giving up smoking? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ Approximate weekly intake? _____

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TOTAL HEALTH

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FAMILY MEDICAL HISTORY

Do any illnesses run in the family such as: Diabetes, Heart Disease, Blood Pressure, Asthma, Glaucoma, Stroke?
(Please add age at onset of serious illness or death)

	If Alive	If not Alive
Father		
Mother		
Brothers		
Sisters		

ALCOHOL

How often do you have a drink containing alcohol?

Never ☐ Monthly or less ☐ 2-4 times a month ☐

2-3 times a week ☐ 4 or more times a week ☐

How many standard drinks containing alcohol do you have on a typical day?

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐

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

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

SOCIAL

Are you caring for a partner / relative / friend / or person who cannot manage without help because of illness / age / disability of any kind? Yes No

If Yes please give name and age of person (s) you care for

_____

_____

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FEMALE PATIENTS ONLY

How many pregnancies have you had? _____

Have you ever had a cervical smear? Yes ☐ No ☐

When ? _____ What was the result? _____

Contraception – Do you use the Pill / Injection / Coil / Condoms / Other? If so what?

…… or none?

REPEAT PRESCRIPTIONS

Please indicate your preferred medication collection point for repeat prescriptions:

Stowhealth dispensary	☐	Boots (Violet Hill House)	☐
Boots (Town)	☐	Tesco (Cedars Park)	☐
Solar	☐	Asda (Stowmarket)	☐

If you live more than one mile from a registered pharmacy, Stowhealth is able to dispense your prescriptions. Please tick box if is this applies ☐

STOWHEALTH INFORMATION

We are open for enquiries between 08:00 and 18:00 Monday – Friday. Details of our services and our staff can be found on the web site.

We would also like to advise you of the many other services now available at Stowhealth; our Complementary Medicine Shop and Complementary Therapy Team including acupuncture, reflexology, spiritual healing, shiatsu, herbal medicine, allergy therapy, homeopathy, hypnotherapy, counselling and psychotherapy, clinical psychology and NLP.

Please ask any member of staff for full details or to collect relevant leaflets

Your Signature _____ ***Date*** _____

Thank you for completing this form!