MORLAND HOUSE SURGERY NEW PATIENT QUESTIONAIRE

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Full Name:
Occupation:
Date of Birth: / /
Marital Status:

Address:
Postcode:

Date moved to this address?

Home Phone Number: Mobile Number:
Email Address:

Next of Kin Details
Name:
Contact Number:
Relationship to Patient:
Address if different to yours:

Carer Details
Do You Care For a Friend or Relative?
If Yes please provide -
Name:
Contact No:

Are You Cared for by a Friend or Relative?
If Yes please provide -
Name:
Contact No:

Please tick the box on the right if you agree to be contacted from time to time via email and/or SMS text message with appointment reminders and/or advice about

Armed Forces
Have you ever served in the Armed Forces? Yes / No * * Delete as appropriate

Personal Health Details
This Surgery, in line with other healthcare providers, collects information about health issues and ethnic groups of patients, This information can help us plan to meet the needs of the community and ensure that everyone has equal access to the health care we provide.

Weight: Height:

Are you on regular/repeat medication? Yes / No * * Delete as appropriate
If so, please bring copy of repeat slip to your first GP Appointment

Smoking Status (please circle): Never Smoked Ex-Smoker Current Smoker

Units of Alcohol Consumed Per Week:

Have you been diagnosed with any of the below (please tick appropriate box(es)?

Asthma	☐	Dementia	☐	Atrial Fibrillation	☐
Cancer	☐	Epilepsy	☐	Rheumatoid Arthritis	☐
Diabetes	☐	Hypertension	☐	Coronary Heart Disease	☐
COPD	☐	Hypothyroidism	☐	Mental Illness	☐

Please list any allergies you may have:

Recording of Ethnic Group and First Language Information for Patients

Please note we are not asking about citizenship or nationality, but about the ethnic group to which you feel you belong and your first language.
All the information we receive will be used and treated with the strictest confidence.
The classification is entirely voluntary but will help us to provide a better service. The level of care you will be offered at this Surgery will not be affected by your decision to complete this form.

If you have any queries about this form please ask one of our receptionists. Otherwise, please complete the form below by ticking the box of the ethnic group you feel you belong to. If you feel you are descended from more than one group, please choose the one you feel you most belong to, or choose the 'Other Ethnic Group' option.

White British	
White Irish	
Other White	
Caribbean	
African	
Other Black	
Mixed White & Black Caribbean	
Mixed White & Black African	
Mixed White & Asian	
Other Mixed	
Indian or British Indian	
Bangladeshi or British Bangladeshi	
Pakistani or British Pakistani	
Chinese	
Other Ethnic Group	

What is your First Language? (e.g. English, French, Hindi)

Accessible Information Standard
Do you have any communication or information needs relating to a disability, impairment or sensory loss? If so, please let us know what they are below

Please self-define your communication / information needs (these needs and not the disability will be recorded in your medical notes)