

The Mounts Medical Centre

NEW PATIENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS FROM PAGE 1-3 AS IT MAY TAKE SOME TIME TO OBTAIN YOUR PREVIOUS MEDICAL HISTORY. USE CAPITAL LETTERS FOR ALL QUESTIONS. DO NOT IN FILL PAGE 4.

Title: MR  MRS MS MISS

Martial Status: Single Married Divorced Widowed

First Name's.....

Surname .....

Date of Birth .....Country of Birth.....

Address.....

Post Code.....Email Address.....

Tel No Home.....Tel No Mobile .....

Tel No Work..... Other Tel No .....

Occupation .....Main Spoken Language .....

Next of Kin's Name.....

Relationship to you .....

Next of Kin's address .....

Next of Kin's telephone number(s).....

Name of Nominated Pharmacy .....

Do you want to subscribe to online Services  Yes  No, if yes you must have a valid email address to avail this facility. Please write down your email address very clearly in CAPITAL ( big ) Letters, as your details will be emailed on this email address. Practice is not responsible if you have provided an incorrect email address.

Are you a Veteran:  Yes  No

Are you a Carer for anyone with a serious illness / disability?  Yes  No

If yes – Do you give permission to us to share your information with Northamptonshire Carers  Yes  No



## ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic Origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origin may help with the early identification of some of these conditions.

Please tick one section from A to E, and then tick which applies to your background.

<b>A</b>	<input type="checkbox"/> <b>WHITE</b>	<input type="checkbox"/> <b>BRITISH</b>
		<input type="checkbox"/> <b>IRISH</b>
		<input type="checkbox"/> <b>ANY OTHER WHITE BACKGROUND</b>
<b>B</b>	<input type="checkbox"/> <b>MIXED</b>	<input type="checkbox"/> <b>WHITE AND BLACK CARIBBEAN</b>
		<input type="checkbox"/> <b>WHITE AND BLACK AFRICAN</b>
		<input type="checkbox"/> <b>WHITE AND ASIAN</b>
		<input type="checkbox"/> <b>ANY OTHER MIXED BACKGROUND</b>
<b>C</b>	<input type="checkbox"/> <b>ASIAN OR ASIAN BRITISH</b>	<input type="checkbox"/> <b>INDIAN</b>
		<input type="checkbox"/> <b>PAKISTANI</b>
		<input type="checkbox"/> <b>BANGLADESHI</b>
		<input type="checkbox"/> <b>ANY OTHER ASIAN BACKGROUND</b>
<b>D</b>	<input type="checkbox"/> <b>BLACK OR BLACK BRITISH</b>	<input type="checkbox"/> <b>CARIBBEAN</b>
		<input type="checkbox"/> <b>AFRICIAN</b>
		<input type="checkbox"/> <b>ANY OTHER BLACK BACKGROUND</b>
<b>E</b>	<input type="checkbox"/> <b>CHINESE OR OTHER ETHNIC GROUP</b>	<input type="checkbox"/> <b>CHINESE</b>
		<input type="checkbox"/> <b>ANY OTHER PLEASE STATE BELOW</b>

Declined to state ethnic origin

(Please tick the box if you would prefer not to state your ethnic origin)

End of this Questionnaire, please do not write anything on the next Page 4 which is the last page of this form, if you do that you will have to submit another form.

## New Patient Health Check

		Y	N	COMMENT
Weight				
Height				
Systolic BP				
Dias BP				
Smoking				
Alcohol				
Diet				
Exercise Grading				
Urine protein				
Urine Glucose				
Urine Blood				
Gen Contra Advice				
<u>Family History</u>				
FH: IHD < 60				
Family member				
FH: IHD > 60				
Family member				
FH: CVA/Stroke				
Family member				
FH: Diabetes				
Family member				
FH: Asthma				
Family member				