

## The Oaklands Practice

### New Patient Questionnaire (Age 16+)

Welcome to our Practice, and thank you for registering with us. It may take some weeks before your records reach us and by answering the following questions you will enable us to provide better medical care.

Surname	Forenames (underline name by which you are known)
Maiden Name	Male/Female <span style="float: right;">Title</span>
Date of birth	Place of birth
Marital Status	NHS No.  Are you a Carer? YES / NO
Address (and postcode)	Home Telephone  Work Telephone  Mobile No.
Name of Next of Kin & Tel No	Name & Address of Previous GP
<p>Please indicate if you have a history of any of the following:</p> <p>High Blood Pressure            YES/NO</p> <p>Stroke                                YES/NO</p> <p>Heart Attack                        YES/NO</p> <p>Angina                                YES/NO</p>	<p>Diabetes                                YES/NO</p> <p>Asthma                                YES/NO</p> <p>COPD (emphysema)                YES/NO</p> <p>Epilepsy                                YES/NO</p>
Any other significant illness or operations?	Current Medication

Date of last Tetanus vaccination	Allergies
Height	Weight
Do you smoke YES/NO Please indicate: cigarettes/cigars/pipe How many per day?	If no, did you ever smoke YES/NO If yes, when did you stop
WE RUN STOP SMOKING CLINICS HERE AT THE MEDICAL CENTRE. Please ask at reception for further details.	

**WOMEN AGED BETWEEN 24 - 60 ONLY**

Have you ever had a cervical smear? YES/NO	If yes, date of most recent smear
Where was it taken? GP/CLINIC/HOSPITAL	What was the result?
Are you taking the contraceptive pill? YES/NO	Are you fitted with a coil (IUCD)? YES/NO

**For our information, how did you hear of our Practice?**

- Neighbour/Friend/Colleague
- Previous occupant of house
- Yellow Pages/Thompson Local
- Web Search
- NHS Choices
- Other (please specify)

**Any other comments or suggestions?**

## The Oaklands Practice

### New Patient Questionnaire (Age 0-15)

Welcome to our Practice, and thank you for registering with us. It may take some weeks before your records reach us and by answering the following questions you will enable us to provide better medical care.

Surname	Forename (underline name by which you are known)
Parent's Surname	Date of Birth
Place of Birth	Male/Female
Address	Name and address of previous GP
Telephone No	Next of Kin and Telephone No
Please indicate if your child has a history of any of the following:-  Diabetes                      YES/NO Asthma                         YES/NO Epilepsy                        YES/NO	Any other significant illness or operations?
Allergies: Has your child ever been allergic to any medicines?	Drugs and Medicines: Please list any drugs or medicines your child is taking
Immunisations: Please give dates and where and by whom (i.e.: GP/Clinic), if known  Dip/Tet/W Cough/Polio/Hib/Pneumo/Men C  1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup>  Hib/MenC  MMR (1 <sup>st</sup> )	Pre School Booster  MMR (booster/2 <sup>nd</sup> )  BCG  Dip/Tet/Polio (leaving school)  Other (please specify)