



New Registration Patient Questionnaire

Welcome to the practice. Please help us by filling in as much of this questionnaire as possible.

Surname : _____ Date & Place of birth : _____
Maiden Name: _____ Marital Status : _____
Forenames : _____
Address : _____ Previous Address : _____

Postcode : _____ Previous Postcode: _____
Ethnic Origin (please chose from codes below) : _____
First language: _____
Next of kin name & contact number: _____

Tel No: _____ NHS Number : _____
Mobile: _____ NHS CARD YES NO
Identification Documents YES NO

Previous GP:

Address :

Your Health (Please use reverse of form if necessary)

Are you allergic to any drugs? YES NO Please give details:

Do you smoke? YES (How many per day?) _____ EX-SMOKER (How many per day?) _____

How old were you when you stopped smoking? _____ NON-SMOKER (and never smoked in the past)

When did you last have a tetanus injection? _____

Ladies: When did you last have a smear? _____ or have you had a hysterectomy(date) _____

Patients Signature.....Date:.....

DO YOU REQUIRE ORGAN / BLOOD DONATION FORM? YES NO

Ethnic data codes

White:

British 01
Irish 02
Other mixed 03

Asian or Asian British:

Indian 08
Pakistani 09
Bangladeshi 10
Other Asian 11

Other Ethnic:

Chinese 15
Other Ethnic category 16

Not stated 17

Mixed:

White & black Caribbean 04
White & black African 05
White & Asian 06
Other mixed 07

Black or Black British:

Black Caribbean 12
Black African 13
Other Black 14