THE WHITE HOUSE SURGERY

Dr Chee Mah
Dr Jonathan Bryant
Mrs Suzanne Ballard

1 CHERITON HIGH STREET FOLKESTONE KENT CT19 4PU Tel 01303 275434 Fax 01303 271921
e-mail – whitehouse.surgery@nhs.net website – www.whitehousefolkestone.nhs.uk

NEW PATIENT INFORMATION QUESTIONNAIRE

TITLE:				
FIRST NAME:				
SURNAME:				
DATE OF BIRTH:				
HOME ADDRESS:				
TEL NUMBER(S):	Home:		Mobile:	
Please tick box if you DO NOT wish to receive text alerts ☐				
NAME & ADDRESS OF PREVIOUS DOCTOR:				
ETHNIC GROUP *Tick box*	White ☐	British/Mixed ☐	White/British ☐	Black African ☐
	Black Caribbean ☐	Black Other ☐	Indian ☐	Pakistani ☐
	Chinese ☐	Vietnamese ☐	Nepalese ☐	
	Other *please specify:*			
WHAT IS YOUR FIRST LANGUAGE:				
ARMED FORCES Please complete as appropriate	**I am**: Currently serving (Regular or Reserve) ☐ Ex-Serving (Veteran) ☐ My British Armed Forces Service Number is: ☐ Enlistment date: Leaving date: An immediate family member of one of the above ☐ Please specify (eg partner, dependant)			
ARE YOU REGISTERED DISABLED ? IF YES, PLEASE GIVE				

DETAILS OF YOUR DISABILITY		
MEDICAL INFORMATION *Please list any serious illnesses/operations/accidents and the year they took place:-*		
HAVE YOU EVER SUFFERED OR DO YOU SUFFER FROM ANY OF THE FOLLOWING:- *Tick box*		
Diabetes	YES ☐ NO ☐	
Epilepsy	YES ☐ NO ☐	
High blood pressure	YES ☐ NO ☐	
Heart disease/angina	YES ☐ NO ☐	
COPD	YES ☐ NO ☐	
Stroke	YES ☐ NO ☐	
Cancer	YES ☐ NO ☐	
Depression/mental health problems	YES ☐ NO ☐	
Asthma	YES ☐ NO ☐	
Thyroid problems	YES ☐ NO ☐	

MEDICATIONS – PLEASE ATTACH A COPY OF YOUR MEDICATION SLIP FROM LAST DOCTOR

PHARMACY FOR EPS (PRESCRIPTIONS) TO BE SENT TO:

ARE YOU ALLERGIC TO ANY MEDICINES AND, IF SO, WHAT?

LIFESTYLE

Do you smoke? Yes ( ) See advice below. Please tick appropriately

How many a day ( )

Ex Smoker ( ) Date stopped……..

Never Smoked ( )

SMOKING ADVICE. If you are a smoker, we would advise you to stop smoking. If you would like advice on stopping smoking , please contact the NHS Stop Smoking Service on 0300 123 1220 or text QUIT to 87034

HOW MANY UNITS OF ALCOHOL DO YOU DRINK IN A WEEK?

WHAT IS YOUR HEIGHT?		WHAT IS YOUR WEIGHT?	
DO YOU HAVE A CARER?	YES ☐ NO ☐		
If so, who?			
ARE YOU A CARER?	YES ☐ NO ☐		

If so, please ask for a carers pack from reception.

CONSENT FOR ANOTHER PERSON TO ACCESS YOUR MEDICAL RECORDS	Persons Name: Date of Birth: Contact Number: Please detail below if this access is to be limited in any way (e.g only for t results, or only for making & cancelling appointements or for a specified time period) **You are responsible for contacting the surgery and removing this consent if /when it no longer applies**

OVER 65's

NAME AND ADDRESS OF NEXT OF KIN: RELATIONSHIP:	

Choose if data from your health records is shared for research and planning by visiting the following website:
https://www.nhs.uk/your-nhs-data-matters

Once you have completed this form, please hand it back in at Reception. Thank you.

February 2020