**Pitcairn Practice**

**New Patient Questionnaire**

We would like to gather some information about you and ask that you fill in the following questionnaire. This will enable us to give you the best possible care.

**Your Details**

Title: Name: DOB:

Ethnic Group:

Do you consent to the surgery leaving you a telephone message? **YES / NO**

If yes, on which number? **HOME / MOBILE / WORK**

**Carer Information**

Do you have a carer? **YES / NO**

If yes, what is their name and contact number?:

Do you consent for your carer to be informed about your medical care? **YES / NO**

Are you a carer? **YES / NO**

If yes, are they a patient of Pitcairn Practice? **YES / NO**

If yes, what is their name, date of birth and relationship to you?:

**Armed Forces**

Are you a Forces Veteran? **YES / NO**

Is your spouse/parent (if you are under 18) currently serving in the Armed Forces? **YES / NO**

**Next of Kin**

Name of NoK: Relationship to you:

Address (if different to yours): Contact Number:

**Medication**

If you are on any repeat medications, please provide the practice with a copy of your repeat prescription from your previous practice. If you are unable to do so, please list them here with the strength and dose:

**SPACE FOR ADDITIONAL INFORMATION**