NEW PATIENT QUESTIONNAIRE - STRICTLY CONFIDENTIAL

This information will be stored on your medical records and will help us provide your medical care.

<table>
<tr><td colspan="2">Full Name:</td><td colspan="2">Previous Surname:</td><td>Date of birth:</td></tr>
<tr><td colspan="2">Full Address:</td><td colspan="3">Contact telephone numbers:
☎Home
☎Mobile
☎Work
☎ Emergency contact
Do you consent to receiving text message reminders?
YES/NO
Email address (if available):</td></tr>
<tr><td colspan="2">Sexual orientation: Which of the following best describes how you think of yourself:
• Homosexual
• Straight
• Gay or Lesbian
• Bisexual
• In another way (please state):</td><td colspan="3">Gender Identity and Trans Status Monitoring:
• Woman (including trans women)
• Man (including trans man)
• Non-binary
• In another way (please state):
• Is your gender identity the same as the gender you were given at birth? YES/NO

Preferred gender pronoun:</td></tr>
<tr><td>Occupation:</td><td>Religion:</td><td>Next of Kin:</td><td colspan="2">Marital Status:</td></tr>
<tr><td>Ethnicity:</td><td>Preferred spoken language:</td><td>Do you need an interpreter?
YES / NO</td><td colspan="2">Have you recently travelled from overseas?
YES/NO
If yes, which country?</td></tr>
<tr><td colspan="2"></td><td colspan="3">If yes, please provide details:</td></tr>
<tr><td colspan="2">Do you have any current medical conditions?</td><td colspan="3">YES / NO</td></tr>
<tr><td colspan="2">Do you have any allergies?</td><td colspan="3">YES / NO</td></tr>
<tr><td colspan="2">Are you a Carer for someone?</td><td colspan="3">YES / NO</td></tr>
<tr><td colspan="2">Are you a Foster Carer?</td><td colspan="3">YES / NO</td></tr>
<tr><td colspan="2">Do you have a Carer?</td><td colspan="3">YES/NO (If yes, please provide a contact name and number)</td></tr>
<tr><td colspan="2">Are you a Military Service Veteran?</td><td colspan="3">YES / NO</td></tr>
<tr><td colspan="2">Are you currently pregnant?</td><td colspan="3">YES / NO (If yes, when is your due date?)</td></tr>
<tr><td colspan="2">How many children do you have?</td><td colspan="3"></td></tr>
<tr><td colspan="2">When did you last give birth?</td><td colspan="3"></td></tr>
<tr><td colspan="2">Did you have a postnatal check?</td><td colspan="3">YES/NO</td></tr>
<tr><td colspan="2">When was your last smear test?</td><td colspan="3"></td></tr>
<tr><td colspan="2">Names and date of birth of Children:</td><td colspan="3"></td></tr>
</table>

Do you take any regular medicines?
YES / NO (If yes, please list all medicines and dosage or attach a copy of your repeat prescription)

Which Chemist would you like to nominate to receive your prescriptions electronically?

Which diseases have you received vaccinations for?

Please circle your current smoking status:

- Smoker
- Ex-smoker
- Never smoked

If you would like help with stopping smoking please ask your local Pharmacy

Height:

Weight:

Please answer all 3 questions and circle your answer:

How often do you have a drink containing alcohol?

N/A NEVER MONTHLY OR LESS 2-4 A MONTH 2-3 A WEEK 4+ WEEKLY

How many units do you drink on a typical day when you have a drink?

N/A 1-2 3-4 5-6 7-9 10+

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

N/A Never Less than monthly Monthly Weekly Daily or almost daily

Additional information:

Please make an appointment for a New Patient Health Check and please bring a urine sample along with you. Patients over the age of 40 will require a blood test.