ST JAMES' MEDICAL PRACTICE
County Court Road, King's Lynn, Norfolk PE30 5SY
Tel: 01553 774221

FOR OFFICE USE ONLY – PROOF OF ID	
A minimum of 2 (including photo ID) required	
Please tick which have been seen:	
Photo driving license	Birth certificate
Passport	Benefits agency book
Bank statement	Driving license
Marriage certificate	Home office papers
Payslip	Medical card
P45	Utility bill

NEW PATIENT QUESTIONNAIRE

PLEASE COMPLETE BOTH SIDES

Please complete this questionnaire today fully and hand into reception.

If you are on repeat medication or have an ongoing condition you wish to discuss, then please arrange an appointment with one of the doctors.

If you have not had your blood pressure taken for at least 4 years and you are over 40 years old, we recommend that you come in and use our blood pressure machine for this important check. Please ask at reception.

Please note that all patients wishing to register will need to show TWO forms of ID.

Title:	Name:		Date of Birth:
Address: Postcode:			
Tel Home:	Mobile:	Work:	Email:
Place of Birth:		County or Country:	
Main Language Spoken:		Do you speak English?	Yes / No

Preferred Method of Contact (please tick one):

Letter ☐ Email ☐ SMS ☐ No Communication ☐

Ethnic Group (please tick relevant group)

White	**Mixed**	**Asian**
British ☐	White and Black Caribbean ☐	British ☐
Irish ☐	White and Black African ☐	Indian ☐
Other white background ☐	White and Asian ☐	Pakistani ☐
	Other mixed groups ☐	Bangladeshi ☐
		Other Asian background ☐

Emergency Contact

Name:	Tel:
Relationship to you:	

Next Of Kin

Name:	Tel:	Relationship:
Address: Postcode:		

If Ex Services

Date of Entry to Service:	Date Discharged From Service:

If you have been living abroad	Date Left UK:	Date Returned to UK:

The following questions are very important for us to make sure we give you the best possible healthcare. Please complete them as fully and as accurately as possible.

PERSONAL DETAILS & MEDICAL QUESTIONS

Height:	Weight:

Alcohol Consumption (Please answer all the questions by ticking which boxes applies to you)

How often do you have a drink containing alcohol?	How many units of alcohol do you drink on a typical day when you are drinking?	How often have you had six units, if female or 8 units if male, on a single occasion in the last year?
• Never ☐ • Monthly or Less ☐ • 2-4 Times a Month ☐ • 2-3 Times a Week ☐ • 4 or More Times a Week ☐	• N/A ☐ • 1 or 2 ☐ • 3 or 4 ☐ • 5 or 6 ☐ • 7 or 8 ☐ • 10 or more ☐	• N/A ☐ • Less than Monthly ☐ • Monthly ☐ • Weekly ☐ • Daily or Almost Daily ☐

Smoking Status:

Do you smoke? **YES** ☐ **NO** ☐	If YES, how many cigarettes do you smoke? per day
If you currently do not smoke, have you smoked previously? **YES** ☐ **NO** ☐	

Do you suffer from any allergies? Have you had an allergic reaction to any medications? (If yes please state what you are allergic to)
Do you suffer from any medical conditions? Please give details:
Are you taking any regular medication?

Do You Have A Family History Of?

Disease	Relationship	Disease	Relationship
Diabetes		Raised Cholesterol	
Heart Disease		Stroke	
Cancer		Other Inherited Conditions	