Questionnaire for patients registering from outside the UK

First Name:	
Surname:	
Date of Birth	

Medical History **Please tick the appropriate boxes if you have been diagnosed with any of the below:**				
Asthma	COPD	Diabetes	Coronary Heart Disease	
Hypertension	Stroke	Epilepsy	Rheumatoid Arthritis	
Mental Illness	Cancer	Dementia	Atrial Fibrillation	
Hepatitis B	Hepatitis C	Tuberculosis	HIV	
Hypothyroidism	Other			
Have you ever been screened for:	HIV	Tuberculosis	Hepatitis C	Hepatitis B
Do you have any allergies? YES/NO	If yes, which ones?			

Prescribed Medication	
Are you on a regular/repeat medication? YES/NO	If yes, which ones?
Are you allergic to any medications? YES/NO	If yes, which ones?

For Women We can provide a full range of contraceptive services at the Surgery.	
Are you Pregnant? YES/NO	If yes, how many weeks?
Have you had a cervical smear in the last 3 years? YES/NO	If yes, Approximately what date? Was it: NORMAL/ABNORMAL?
Have you had a mammogram in the last 3 years? YES/NO	If yes, Approximately what date? Was it: NORMAL/ABNORMAL?
Do you take the contraceptive pill? YES/NO	If yes, do you know what type?
Do you have a coil fitted? YES/NO	If yes, do you know when it was fitted?

Vaccination Status		
Have you been vaccinated against Covid-19?		YES/NO
If yes, what vaccine brand did you have? How many doses have you had?	If no, would you like a vaccination?	
Do you have a copy of your vaccination records?		YES/NO
If no, do you know what vaccinations you have had?		YES/NO

Other NHS services and screening	
Do you have any hearing difficulties?	YES/NO
Do you have any sight problems?	YES/NO
Do you need urgent dental care?	YES/NO
Would you like to be included in routine NHS screening programs? Eg.breast, bowel, cervical cancer screening	YES/NO

Our Website has a translation facility and we can arrange an interpreter for consultations if required.