New Patient Health Questionnaire

To register with the Practice please complete the following questionnaire as fully as possible. This will help the Doctor to make an initial assessment of your health that will help in your future treatment. (Please complete this form in **BLOCK CAPITALS**.)

Surname …… Forenames ……

How would you like to be addressed? ……

Address ……

…… Postcode ……

Date of Birth …… /…… /…… Marital Status ……

Home Tel: Area Code: …… Mobile Tel: ……
Phone No: ……

Do you consent to share your records with other health related teams? i.e. District Nurses, Physiotherapy etc.? Yes ☐ No ☐

Country of Origin: …… Ethnicity: …… Religion: …… Preferred first language/ main language: ……

Do you require an interpreter for your consultations? Yes ☐ No ☐

Do you require translated written materials from the surgery? Yes ☐ No ☐

What is your gender? Male ☐ Female ☐

Is your gender the same as the sex on your birth certificate? Yes ☐ No ☐

How do you identify? Man ☐ Woman ☐ Nonbinary ☐ Prefer to self-describe below ☐

……

Would you like to receive appointment / recall reminders via text? Yes ☐ No ☐

Would you like the surgery to contact you?
(By completing the below information you consent to the practice contacting you.)

Email Address: ……

Signature: …… (Signature must be present.)

Ethnicity …… Occupation ……

For Children Only:

Name of Parent or Guardian …… Relationship ……

Name and Address of School ……

…… Tel No:

Next of Kin

Surname …… Forename(s) ……

Relationship …… Tel No: ……

FAMILY HISTORY

(If there is a history of any of the following illnesses in your family which go back **ONE GENERATION** i.e. Parents, Siblings, Grandparents, Aunts and Uncles. Please record these on the page below.)

Breast Cancer	……	Relationship	……	Age Diagnosed	……
Ovarian Cancer	……	Relationship	……	Age Diagnosed	……
Bowel Cancer	……	Relationship	……	Age Diagnosed	……
Diabetes	……	Relationship	……	Age Diagnosed	……
		Relationship	……	Age Diagnosed	……
Heart Disease	……	Relationship	……	Age Diagnosed	……
(i.e. Heart Attacks, Angina)		Relationship	……	Age Diagnosed	……
High Blood Pressure	……	Relationship	……	Age Diagnosed	……
Stroke	……	Relationship	……	Age Diagnosed	……
High Cholesterol	……	Relationship	……	Age Diagnosed	……
Other Cancer	……	Relationship	……	Age Diagnosed	……

Allergies – Please give details of any known allergies.

……

Medication – Please give details of any prescribed or over the counter medicines you are taking. If you have a repeat slip from your previous Doctors' Surgery please bring this along so that the Medications can be transferred to your Medical Record here.
If you live less than 1 mile from a chemist please nominate the one you would like your electronic prescriptions to be sent to, please inform us of their name and address.

PAST MEDICAL HISTORY (including Treatment and Operations)

Female Patients Only:

Date of most recent Cervical Smear …… /…… /……

Result of most recent Cervical Smear ……

ARMED FORCES

Are you ex-military? (XE0pb) Yes ☐ No ☐

Are you a family member of a current or ex-military family? Current ☐ Ex-military ☐ N / A ☐

CARERS

Are you an informal carer? (XaL3P) Yes ☐ No ☐

Is that person registered with this surgery? Yes ☐ No ☐

If '**Yes**' please give the Name and Date of Birth of this relative:

Surname: …… Forename(s): ……

(RECEPTION – to provide patient with Carers' Questionnaire if patient is a carer)

SMOKING

(Please tick the boxes and fill in the appropriate sections that apply to you.)

Do you Smoke? Yes ☐ No ☐

If '**Yes**', how many Cigarettes per day? ……
Cigars per day? ……
Ounces of Tobacco per day? ……

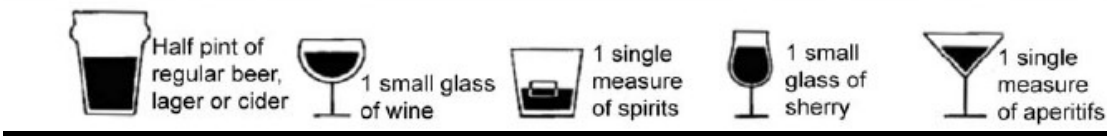
Are you an Ex-Smoker? Yes ☐ No ☐

If '**Yes**', how many Cigarettes per day? ……
Cigars per day? ……
Ounces of Tobacco per day? ……

Never Smoked Tobacco? ☐

ALCOHOL CONSUMPTION

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Provided by www.alcohollearningcentre.org.uk

Is there anything else you would like us to know?

……

……

……

……

……

DISABILITY STATUS

Do you have a disability which affects your ability to communicate or access information?

Learning disability?	Yes ☐ No ☐	If yes, please give details: ……
Visual loss?	Yes ☐ No ☐	If yes, please give details: ……..
Hearing loss?	Yes ☐ No ☐	If yes, please give details: ……..
Communication difficulties? e.g. stroke/brain injury	Yes ☐ No ☐	If yes, please give details: ……..
Autism?	Yes ☐ No ☐	If yes, please give details: ……..
Dementia?	Yes ☐ No ☐	If yes, please give details: ……..

If you have answered **yes** to one of the above:

I communicate using: (e.g. BSL (British Sign Language), family member, speech to text reporter)

……

To help me communicate I use: (e.g. a talking mat, hearing aids)

……

I need information in: (e.g. braille, easy read, large print)

……

If you need to contact me, the best way is: (e.g. email, telephone, text, letter)

……

Do you need any other communication support? (e.g. a longer appointment, loop system, providing paper and pen)

……