Holyhead Primary Healthcare Centre
New Patient Questionnaire Form

1 St. James Rd ; Handsworth, Birmingham B21 0HL. Phone:0121 5548516

Instructions:

Please complete this confidential personal health questionnaire **(one for each member of the family to be registered with the Practice)**. which is designed to help you prepare for a checkup with your doctor—giving you clues to discuss during your visit.

Even if you think your doctor already knows this stuff about you, or that the answers to these questions are somewhere in your medical files, it helps to take a totally fresh look at yourself today using these particular inquiries.

Most of these questions are meant to be answered with regard to the present day, Spend time with this document. Fill it out in a comfortable place where you don't have any distractions.

Your answers are your own. We encourage you to fill it online and print, sign (or) print this questionnaire out and write your answers directly onto the page.

1) Respond to each question carefully and honestly.
2) You are required to present in person to sign **Health Questionnarie form** and hand it in at reception.

Fields marked in red are compulsory.

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate, **print and hand it in at reception:**

Today's Date

I have read and under stand the Instruction

☐

Patient Information

Title

Date of Birth

Surname

NHS No.

First name(s)

Sex

Previous name (if different)

Marital Status

Occupation

No.Of Children

Contact Information

Home Address

How Long you been living in this property

Post Code

Telephone No

Mobile No

e-mail ID

Please help us trace your previous medical records by providing the following

Name of Previous GP

Previous GP Address

Your Previous address in UK

About You :

Your Height (cm/ft)

Your Weight (stones/lbs/kg)

Your Religion

- ◯ C of E
- ◯ Buddhist
- ◯ Sikh
- ◯ No religion
- ◯ Other Please state
- ◯ Catholic
- ◯ Hindu
- ◯ Jewish
- ◯ Other Christian
- ◯ Muslim
- ◯ Jehovah's Witness

Ethnic Group

White

◯ British ◯ Irish

◯ Other

Black

◯ African ◯ Caribbean

◯ Other

Asian

◯ Indian ◯ Pakistani ◯ Chinese

◯ Other

Mixed background Please specify :

What languages do you speak well :

****Only for EEA members who have come to UK in the Last Year.**

European Health Insurance Card (**EHIC)** number :

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?

◯ Yes

◯ No

If NO, Have you ever been a smoker?

◯ Yes

◯ No

If so, how many cigarettes / cigars / tobacco do you smoke in a day?

Would you like advice on giving up smoking?

◯ Yes ◯ No

When did you quit smoking ?

How much alcohol do you drink in a week (Units)?
(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)

How often do you physical activity / exercise?

◯ Inactive ◯ Moderately Inactive ◯ Moderately active
◯ Active

Medical Information :

Please list any serious illnesses / operations / accidents / disabilities (and for women any pregnancy related problems) and the year they took place

What operations have you had and When?

What operations have you had and When?

Please list any tablets, medicines or other treatments you are currently taking:
(incl. dose + frequency)

Any family history of serious diseases that affect your Parents, Brothers or Sisters
(Please specify clearly)

What immunisations have you had? (please tick all that apply)

☐ Diphtheria ☐ Measles ☐ German Measles
☐ Tetanus ☐ Polio ☐ MMR
☐ Whooping Cough ☐ Pre-school booster ☐ Triple vaccine
☐ Other

Have you ever refused treatment/screening of any kind and if so, what and when?

Are you a Carer ?

◯ Yes ◯ No

If yes please give details (name / address / phone number) of the person you care for: :

Do you have a Carer ?

◯ Yes ◯ No

If yes please give their details (name / address / phone number) :

You wish us to disclose information about your health to your Carer Please sign Here

☐ **I wish my GP to disclose information about my health to my Carer.**

Patient Signature

Signature on behalf of Patient

Specific Needs :

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):

Are you an 'Assistance Dog' User?

◯ Yes ◯ No

Please state any Physical disabilities you have:

Please state any Mental disabilities you have:

Please state any requirements you have to be able to access the Practice premises :

Please state any Religious or Cultural needs:

Do you require the help of a Translator / Interpreter? If so Please specify details

Please state any specific nutritional requirements you have:

Please state any allergies and sensitivities you have:

Please state any phobias you have:

Woman Only :

When was your last smear done?

Was this at your GP's Surgery?

◯ Yes ◯ No

◯ Other

What was the result of the smear?

Date of last mammogram (if applicable):

Method of contraception (if used):

Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?

◯ Yes ◯ No

I declare to the best of my belief this information is correct

Patient Signature

Signature on behalf of Patient

Thank you for completing this form For more information about the services we offer, please refer to your new patient pack

GP Practice Use only *(filled by staff only)*

Info

Staff Signature

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