New Patient Health Questionnaire for Adults

Your Contact Details

Title		Surname	
Date of Birth		First Name	
Occupation		Previous Surnames	
Home Address		Home Tel	
		Work Tel	
		Mobile	
Postcode		Email	

Please provide an email address where possible

Information About You

What is your height? ____________ What is your weight? ____________

What is your first language? ____________

Do you need an interpreter? ☐ YES ☐ NO

Do you have a sight/hearing impairment or NEED information in a different format? ☐ YES ☐ NO

Ethnic Group

White	☐ British	☐ Irish	☐ Other	*If other please specify*
Black	☐ Caribbean	☐ African	☐ Other	*If other please specify*
Asian	☐ Indian	☐ Pakistani	☐ Chinese ☐ Other	*If other please specify*
Mixed	☐ White + Black African ☐ White + Asian		☐ White + Black Caribbean ☐ Other	*If other please specify*

Previous GP

Name and Address of Previous GP ____________

Proof of Identity and Address Provided

☐ Birth Certificate	☐ Driving Licence	☐ Passport	☐ Utility Bill	
☐ Allowance Book	☐ Solicitor's Letter	☐ Tenancy Offer	☐ Other	*If other please specify*

Medical Information

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

Have you ever suffered from ? (tick as appropriate)

Epilepsy	☐ Yes	☐ No	Blindness/Glaucoma	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Attack/Stroke	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Eczema/Hay Fever	☐ Yes	☐ No	COPD	☐ Yes	☐ No

If yes to any of the above, please state the year(s) when you were first diagnosed?

Please list any medicines being taken and the amount:

Are you registered disabled? (If yes, please give details) ☐ Yes ☐ No

Are you allergic to any medicines and if so, which? ☐ Yes ☐ No

Have you ever refused treatment/screening of any kind and if so, what? ☐ Yes ☐ No

Have you ever suffered from ? (tick as appropriate)

Anxiety	☐ Yes	☐ No	Depression	☐ Yes	☐ No
OCD	☐ Yes	☐ No	Bipolar Disorder	☐ Yes	☐ No

If yes to any of the above, please state the year(s) when you were first diagnosed?

Do you have any other mental health issues? (If yes please give details)

Are you receiving or have you received any treatment or therapy? (If yes please give details of your care and when you received it)

Carers (Carer Information Pack available at Reception)

Do you have a carer? ☐ Yes ☐ No
(If yes please give name & contact details here and ask your Carer to complete a Carer Identification Form at the surgery)

Are you a carer? ☐ Yes ☐ No
Do you look after someone at home who could not manage without your help?
(If yes please give name & address of the person you care for and make sure you complete a Carer Identification Form at the surgery

Will

Do you hold a Living Will? ☐ Yes ☐ No
(A Living Will is documentation about your personal wishes regarding medical intervention at the time of serious illness)

Women

Have you ever had a cervical smear? If yes, please state when and where. ☐ Yes ☐ No

Smoking

Do you smoke? ☐ Yes ☐ No

If 'No', have you ever smoked? ☐ Yes ☐ No

If you currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

Would you like advice on giving up smoking? ☐ Yes ☐ No

Alcohol

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

1. **MEN:** How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

☐ Never ☐ Yes, on one occasion ☐ Yes, on more than one occasion

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual, and in the case of cancer, the type of cancer.

____

____

Next of Kin: Please give name, address and telephone number of your next of kin

Name: ______________________________

Address: ______________________________

Telephone Number: ______________________________

Relationship to you: ______________________________

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? ☐ Yes [ ] Date ☐ No

Have you had a pneumococcal vaccination? ☐ Yes [ ] Date ☐ No

Contacting You

I agree that I may be contacted from time to time, via email and/or SMS, with Practice news, advice about my health and/or appointment reminders. ☐ Yes ☐ No

I confirm that the information I have given in this New Patient Questionnaire is correct.

Signature ______________________________ **Date** ______________

(you will be asked to sign this form when you visit the Practice)

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Forms & Questionnaire checked? ☐ Yes ☐ No

Has patient declined to take blood pressure reading? ☐ Yes ☐ No

All ID Document provided, checked and valid? ☐ Yes ☐ No

Has patient been informed of Named GP? ☐ Yes ☐ No

Who is the named GP? ______________________________

Name & signature of staff member: ______________________________