**Date Form Completed:**

**In order to be fully registered with this practice, this form MUST be completed in full**

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| **NEW PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 +)** | | | | | | | | | | | | | | |
| **TITLE:** |  | | | | **FIRST NAME:** | | | |  | | | | | |
| **SURNAME:** | | **CURRENT SURNAME:** | | | | | | | | | | | | |
| **PREVIOUS SURNAMES:** | | | | | | | | | | | | |
| **DATE OF BIRTH:** | |  | | | | **GENDER:** | | | **M F**  (please tick) | **MARITAL STATUS** | | | |  |
| **ADDRESS :** | | | | | | | | | **WHO ELSE LIVES IN THIS HOUSEHOLD?**  **(**please tell us their names and DOB so we can link up your records**)** | | | | | |
| **Postcode:** | | | | | | | | |  | | | | | |
| **HOME TEL:** | | |  | | | | **MOBILE TEL:** | | | |  | | | |
| **EMAIL ADDRESS:** | | |  | | | | | | | | | | | |
| **CAN WE LEAVE MESSAGES ON THESE NUMBERS?** | | | | | | | **MOBILE:** | | | | | | **YES NO** (please tick) | |
| **HOME:** | | | | | | **YES NO** (please tick) | |
| **Would you like to register with the Practice for SMS text messaging (This will include appointment reminders, some test results and any other useful information)?** | | | | | | | | | | | | | **YES NO** (please tick) | |
| **OCCUPATION**: (previous occupation if retired) | | | | | | | |  | | | | | | |
| **ARE YOU A CARER?** | | | | **YES NO**  (please tick) | | | | **Is so tell us who you care for** | | | |  | | |
| **DO YOU HAVE SOMEONE WHO IS A CARER TO YOU?** | | | | **YES NO**  (please tick) | | | | **If so tell who your carer is** | | | |  | | |

HOW DID YOU FIND OUT ABOUT THE PRACTICE / DECIDE TO REGISTER WITH US?

I've been registered here before I have family registered here General word of mouth

NHS helpline or website

|  |  |  |
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| **Section 1 MEDICAL HISTORY**  **1a Do you have/have you had any of the following conditions?** (please tick) **:**  **High Blood Pressure**  (Please add approximate date of diagnosis if known) **YES NO Diabetes**  (Please add approximate date of diagnosis if known) **YES NO Heart Disease**  (Please add approximate date of diagnosis if known) **YES NO Angina**  (Please add approximate date of diagnosis if known) **YES NO Epilepsy**  (Please add approximate date of diagnosis if known) **YES NO Stroke**  (Please add approximate date of diagnosis if known) **YES NO Asthma**  (Please add approximate date of diagnosis if known) **YES NO Cancer**  (Please add approximate date of diagnosis if known) **YES NO**  **If Asthmatic, have you used your inhaler in past 12 months? YES NO**  **1b We would like to know if you have any conditions that might cause you to be vulnerable** (please tick) **:**  **Dementia**  (Please add approximate date of diagnosis if known) **YES NO Drug or alcohol problems**  (Please add approximate date of diagnosis if known) **YES NO Mental Health Problems**  (Please add approximate date of diagnosis if known) **YES NO A learning disability**  (Please add approximate date of diagnosis if known) **YES NO**  **Contact with a Social Worker** *(if so please can you tell us their name)* **YES NO A Physical disability**  (Please add approximate date of diagnosis if known) **YES NO**  **Have you ever been cared for by the prison medical services? YES NO**  **Do you have any other illness or conditions that might cause you to be vulnerable or do you need to give us more details about things you have mentioned already?**  **1c Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had** (please continue on a separate sheet if needed**:**  **Date: Date: Date: Date: Date: Date: Date:** | |  |
|  | **Section 2 FAMILY HISTORY** | |
|  | **Has a first degree relative (parent or sibling) suffered from any of the following conditions?** (please tick) | |

|  |  |  |  |  |  |  |  |  |  |  |
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| **Cancer** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Stroke** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Heart Disease** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Diabetes** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Asthma** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **High Blood Pressure** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **High Cholesterol** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Glaucoma** | | **YES** | **NO** |  | **Who**  **?** |  | | **At what age?** | |  |
| **Do any other illnesses run in your family? YES NO**  **If Yes, Please give details:** | | | | | | | | | | |
| **Please give details of the current state of your family’s health:** | | | | | | | | | | |
|  | **Age** | | | **State of Health** | | | **Age at death** | | **Cause of Death** | |
| **Father** |  | | |  | | |  | |  | |
| **Mother** |  | | |  | | |  | |  | |
| **Brothers and Sisters** |  | | |  | | |  | |  | |

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| **Section 3 MEDICATION** | | | |
| **3a ARE YOU ON ANY REGULAR MEDICATION?** | **YES** | **NO** | (please tick) |
| **If Yes, please tell us the name and dose:** (if you have a list from your previous GP please give us a copy)  (Please note you may be need to see the doctor for a first repeat prescription to be issued)  **PLEASE NOMINATE A LOCAL CHEMIST:** | | | |
| **3c ARE YOU ALLERGIC TO ANY MEDICATION?** | **YES** | **NO** | (please tick) |

|  |  |
| --- | --- |
| **If Yes, please tell us the type of reaction and name of the medication that caused it :** | |
| **3c ARE YOU ABLE TO MANAGE YOUR MEDICATION YOURSELF?** | **YES NO** (please tick) |

|  |  |
| --- | --- |
| **Section 4 WOMEN ONLY** | |
| **Date of last smear** |  |
| **What was the result?** |  |
| **Are you using any contraception?** |  |
| **Number of children and their year of birth** |  |
| **Are you pregnant now? YES NO** (please tick) | |

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| **Section 5 SMOKING HABIT** | | | | |
| **Are you a current smoker?** | **If Yes** | | **If No** | |
| **No. Cigarettes per day?** |  | **Have you ever smoked?** |  |
| **YES NO** (please tick) |
|  | **No. Cigars per day?** |  | **If yes, what year did you stop?** |  |
| **Pipe tobacco per week? (oz / grams)** |  | **How many *did* you smoke per day?** |  |
| **Would you like help to stop?** | **YES NO** | | |

|  |  |
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| **Section 6 ALCOHOL INTAKE** | |
| **Do you drink alcohol?** | **YES NO** (please tick) |
| **If Yes: Wines / Spirits: units per week** |  |
| **Beer: units per week** |  |
| 1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer | |

|  |  |
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| **Section 7 EXERCISE HABIT** | |
| **Do you take regular exercise?** | **YES NO** (please tick) |
| **If Yes: What sort? :**  **eg. Walking, swimming etc** |  |
| **For how long at any one time?** |  |

|  |  |
| --- | --- |
| **How many times weekly?** |  |

For Office Use:

|  |  |
| --- | --- |
| Registration accepted |  |
| Form scanned |  |
| Details entered on EMIS |  |
| Any vulnerability identified? (section 1b)  If so ensure that a registration  medical is booked. |  |
| Flag if unable to manage own meds (section 3c) |  |

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

|  |  |
| --- | --- |
| **A. White** | |
| British |  |
| Irish |  |
| Polish |  |
| **Any other white ethnic group, please specify below:** | |
|  | |
|  | |
| **C. Asian, Asian British** | |

|  |  |
| --- | --- |
| **B. Mixed or multiple ethnic groups** | |
| Any mixed or multiple ethnic group |  |
|  | |
| **D. African** | |
| African, African British |  |
| **Other African, please specify:** | |
|  | |
|  | |

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| Pakistani, or Pakistani British |  |  | **E. Caribbean or Black** | |
| Indian, Indian British |  | Caribbean, Caribbean British |  |
| Bangladeshi, Bangladeshi British |  | Black, Black British |  |
| Chinese, Chinese British |  | **Other Caribbean or Black, please specify:** | |
| **Other Asian, please specify:** | |  | |
|  | |  | |
|  | | **Other, please specify:** | |
| **If you would prefer not to provide this information, please tick here:** |  |  | |

**ETHNICITY & LANGUAGE QUESTIONNAIRE**

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

NAME DOB

What is your main language?

Do you need an interpreter or sign language support? **Yes No**

We would be grateful if you could complete **one form for each family member** within/joining the

**FOR OFFCE USE:**

|  |  |
| --- | --- |
| Reg details to computer |  |
| NHS no |  |
| Scanned |  |
| Sent to H/V S/N service |  |