Date Form Completed:	

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

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

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)

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				

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)

3b 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)	

Section 5 SMOKING HABIT				
Are you a current smoker?	**If Yes**		**If No**	
YES NO (please tick)	**No. Cigarettes per day?**		**Have you ever smoked?**	
	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**		

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	

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:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian British

D. African	
African, African British	
Other African, please specify:	

Pakistani, or Pakistani British	
Indian, Indian British	
Bangladeshi, Bangladeshi British	
Chinese, Chinese British	
Other Asian, please specify:	
If you would prefer not to provide this information, please tick here:	

E. Caribbean or Black	
Caribbean, Caribbean British	
Black, Black British	
Other Caribbean or Black, please specify:	
Other, please specify:	

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	