**NEW PATIENT HEALTH QUESTIONNAIRE FOR ADULTS**

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| **Your Contact Details** |

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| --- | --- | --- | --- |
| Title |  | Surname |  |
|  |  |  |  |
| Date of Birth |  | First Names |  |
|  |  |  |  |
| Occupation |  | Previous Surnames |  |
|  |  |  |  |
| Home Address (inc. flat number if appropriate)  Postcode |  | Home Tel |  |
|  |  |
| Work Tel |  |
|  |  |
| Mobile |  |
|  |  |
| Email |  |
|  |  |  |  |
| **Information About You** | | | |

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| --- | --- |
| What is your height? |  |
| What is your weight? |  |
| What is your first Language? |  |

Do you need an Interpreter? 🞎 Yes 🞎 No

**Ethnic Group**

**White** 🞎 British 🞎Irish 🞎Other

**Black**  🞎 Caribbean 🞎 African 🞎Other

**Asian** 🞎 Indian 🞎Pakistani 🞎 Chinese 🞎Other

**Mixed** 🞎 White & Black Caribbean

🞎 White & Black African

🞎 White & Asian

🞎 Other

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| **Previous GP** |
| Name and Address of Previous GP |
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| **Proof of Identity and Address Provided** |

🞎Birth Certificate 🞎Driving Licence 🞎Passport

🞎Utility Bill 🞎Allowance Book 🞎 Solicitor’s Letter

🞎Offer of Tenancy 🞎Other

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| **Medical Information** |
| Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems and the year they took place. |
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Have you ever suffered from? (tick as appropriate)

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| --- | --- | --- | --- |
| **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, please state the year(s) when you were first diagnosed?

Please list any medications being taken and the amount:

Pharmacy

All prescriptions are sent electronically

please confirm you pharmacy

otherwise prescription will not be processed

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 and when?

🞎 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 these, 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)

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| **Carers** | |
| Do you have a carer?(if yes please give details) | 🞎 Yes 🞎No |
| Are you a carer? (if yes please give details) | 🞎 Yes 🞎No |

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| **Will** | |
| Do you hold a Living Will? | 🞎 Yes 🞎No |

(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

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| **Women** |

Have you ever had a cervical smear? (if yes, please state when, where and the result) 🞎 Yes 🞎No

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| **Smoking** | |
| Do you smoke? | 🞎 Yes 🞎No |
| If ‘No’, have you ever smoked? | 🞎Yes 🞎No |
| If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per day? |  |
| Would you like advice on giving up smoking? | 🞎Yes 🞎 No |

|  |  |
| --- | --- |
| **Alcohol** | |
| 1 unit = ½ pint of beer or 1 small glass of wine or 1 single spirit | |
| Do you drink Alcohol? | 🞎 Yes 🞎 No |
| If yes, How many units per week? |  |

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| **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.

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| --- | --- |
| **Next of Kin** | |
| Name |  |
| Address |  |
| Telephone Number |  |
| Relationship of Next of Kin |  |

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| --- | --- |
| **For patients aged 65 and over or those with a chronic disease(e.g. asthma or diabetes)** | |
| Have you had a flu vaccination? Enter date or ‘never’ |  |
| Have you had a pneumococcal vaccination? Enter date or ‘never’ |  |

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| **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. 🞎

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| **Signature** |

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

**Signature Date**