NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for joining our practice. As we do not have your medical records yet it would be very helpful if you could fill in all parts of this form and give as much information as possible and then hand in to reception. You may wish to book an appointment at reception when you hand in your forms please do so.
THE INFORMATION YOU GIVE IS CONFIDENTIAL AND WILL ONLY BE USED FOR/IN HEALTH RELATED SETTINGS.
PLEASE REFER TO PRACTICE LEAFLET ON HEALTH RECORDS.

REGISTRATION INFORMATION:

PERSONAL DETAILS:

SURNAME: _____ FORNAMES: _____

TITLE: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE NUMBER WITH DIALLING CODE:

HOME NUMBER _____ WORK NUMBER: _____

MOBILE NUMBER: _____ EMAIL: _____

DO YOU WISH TO BOOK/CANCEL APPOINTMENTS/ORDER PRESCRIPTIONS ONLINE? YES / NO

OCCUPATION: _____

MAIN LANGUAGE SPOKEN: _____
DO YOU NEED AN INTREPRETER? YES OR NO? _____

NEXT OF KIN/RELATIONSHIP _____ TEL NO: _____

MEDICAL HISTORY

HAVE YOU EVER HAD ANY MEDICAL PROBLEMS IN THE PAST REQUIRING HOSPITAL CLINIC ATTENDANCES? SURGERY OR REPEATED VISITS TO THE DOCTOR? PLEASE LIST WITH DATES

_____

_____

ARE YOU ON ANY MEDICATION/TABLETS INCLUDING THE CONTRACEPTIVE PILL? PLEASE LIST INCLUDING DOSE AND FREQUENCY

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICINES SUCH AS PENICILLIN, DUST, AND HAYFEVER? ANIMALS ETC. PLEASE LIST

_____

_____

FAMILY HISTORY – IS THERE ANY FAMILY MEMBER WITH HISTORY OF

DIABETES YES OR NO? IF YES WHICH FAMILY MEMBER? (Please state which side of family- paternal/maternal)

_____

HYPERTENSION (HIGH BLOOD PRESSURE) YES OR NO? IF YES WHICH FAMILY MEMBER?

_____

HEART ATTACKS, ANGINA ETC YES OR NO? IF YES WHICH FAMILY MEMBER

_____

STROKE (CVA) YES OR NO? IF YES WHICH FAMILY MEMBER?

_____

ASTHMA/ALLERGIES YES OR NO? IF YES WHICH FAMILY MEMBER

_____

ANY CANCERS YES OR NO? IF YES, WHICH CANCER AND WHICH FAMILY MEMBER?

_____

HEALTH DATA

DO YOU TAKE REGULAR EXERCISE (AT LEAST 3 TIMES WEEKLY FOR 20MINS)? YES OR NO? _____

DO YOU SMOKE? YES OR NO _____
CIGARETTES? YES OR NO? _____ ROLL UPS? YES OR NO?_____
OTHER YES OR NO? _____
HOW MANY CIGARETTES? 0-10 DAILY _____ 11-20 DAILY_____ 20+ _____
IF OTHER PLEASE GIVE DETAILS: _____
WOULD YOU LIKE TOGIVE UP SMOKING? YES OR NO? _____

ON AVERAGE HOW MANY DAYS A WEEK DO YOU DRINK? _____
HOW MANY DRINKS PER DAY? PINTS _____ GLASSES _____ WINE/SPIRITS_____

PLEASE COMPLETE THE TABLE ON PAGE 3.

DO YOU EAT A VARIED DIET? IF NOT OR IF YOU ARE ON A SPECIAL DIET PLEASE GIVE DETAILS
WRITE YES OR NO.

HEALTHY DIET_____ VEGAN DIET_____ VEGETARIAN_____ LOW FAT DIET_____
LOW SALT _____ OTHER- PLEASE GIVE DETAILS _____
WHEN WAS YOUR LAST BOOSTER GIVEN FOR TETANUS _____ POLIO _____

FOR WOMEN ONLY

HAVE YOU EVER HAD ANY PREGNANCIES? IF SO WHEN? _____
WHEN WAS YOUR LAST CERVICAL SMEAR? _____ WAS IT NORMAL? YES OR NO? _____

HAVE YOU HAD ANY ABNORMAL SMEAR RESULTS IN THE LAST 5YEARS? YES OR NO? IF YES PLEASE GIVE DATES AND DETAILS OF ANY TREATMENT AND PROVIDE COPIES AS PROOF TO ADD TO YOUR RECORDS

_____

_____

WHEN WAS YOUR LAST MAMMOGRAM? WAS IT NORMAL YES OR NO? PLEASE GIVE DETAILS OF ANY TREATMENTS YOU HAVE HAD

_____

PATIENT PROFILING

The practice in line with other healthcare providers and all other statutory services is now collecting profiling information about our patients, which includes ethnicity. This information will help us learn more about the health needs of our local community and allow us to plan services to meet those health needs competently.

All information we receive will be used and treated with the strictest of confidence.

If you have any queries about completing this form please ask a member of staff. Otherwise please complete the form below and please TICK which of the ethnic group you feel you belong to. Thank you

PATIENT NAME _____
DATE OF BIRTH _____

WHITE BRITISH _____
WHITE IRISH _____
OTHER WHITE _____

WHITE/BLACK CARRIBBEAN _____
WHITE/BLACK AFRICAN _____
WHITE/ASIAN_____
OTHER MIXED _____

INDIAN _____
PAKISTANI _____
BANGLADESHI _____
OTHER ASIAN _____

BLACK OR BLACK BRITISH_____
BLACK CARRIBBEAN _____
AFRICAN _____
OTHER BLACK_____
CHINESE OR OTHER ETHNIC GROUP _____

OTHER: _____

PATIENT CONSENT

I CONFIRM THAT I AM ELIGABLE TO RECEIVE NHS TREATMENT AND WILL NOTIFY THE PRACTICE OF ANY CHANGE TO MY APPLICATION IN THAT REGARD.
I ALSO AGREE TO INFORM THE PRACTICE IF I CHANGE MY ADDRESS/MOBILE/PERSONAL DETAILS IMMEDIATELY SO THEY CAN UPDATE MY MEDICAL RECORDS.
AS A PRACTICE WE ARE PART OF THE NHS AND LOCAL COMMUNITY AND I AGREE TO SHARING INFORMTION ABOUT ME FOR NATIONAL SCREENING OR FOR EMERGENCY SERVICES DURING TIMES WHEN THE PRACTICE IS CLOSED (WEEKENDS, EVENINGS ETC) AND I SHALL NOTIFY THE PRACTICE MANAGER IF THIS CHANGES.
In addition to provide better care my GP practice may contact me by SMS (text message)/Telephone /Email/Post. This will chiefly be for a reminder of my appointment date/time. Alternatively opt-out: ☐

THE FAST ALCOHOL SCREENING TEST (FAST)

Questions	**Scoring scheme**					**ENTER SCORE BELOW**
	0	**1**	**2**	**3**	**4**	
1) How often do you have 8 (for men) or 6(for women) or more drinks on one occasion?	Never	less than monthly	monthly	weekly	daily or almost daily	
	Only consider questions 2,3 and 4 if the response to question 1 is less than or equal to monthly					
2) How often during the last year have you been unable to remember what happened the night before because you have been drinking?	Never	less than Monthly	monthly	weekly	daily or almost daily	
3) How often during the last year have you failed to do what is normally expected of you because of your drinking?	Never	less than Monthly	monthly	weekly	daily or almost daily	
4) In the last year has a relative or friend, or a doctor or a health worker been concerned about your drinking or suggested you cut your drinking down?	No		yes, on One Occasion		yes, on more than one occasion	
						Total:

SCORING

A score of 0 on the first question indicates FAST negative
A total of 1-2 on the first question then continue with the next three questions.
A total of 3-4 on the first question stop screening at the first question
An overall total score of 3 or above is FAST positive.

Documents for registering – Please bring these with you when registering as we cannot process your registration without them.
Please bring A proof of Address ie; Utility bill, Bank Statement, Council Tax bill, Tenancy Agreement.
A proof of Identity ie; Passport, Birth certificate or driving license
Thank you

THE NEXT SECTION IS ONLY FOR THE HCA OR PRACTICE NURSE OR DOCTOR TO COMPLETE ONLY

WEIGHT:

HEIGHT:

BP READING:

BMI:

URINALYSIS: **PROTEIN:** _____ **GLUCOSE** _____

HEALTH PROMOTION ADVICE GIVEN YES OR NO? _____

ADVICE LEAFLETS GIVEN YES OR NO? _____