# New Patient Health Questionnaire

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

When registering you need to bring proof of address such as a recent household bill

Please complete a separate form for each family member to be registered.

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| **Full Name:** | | | | | | | | | | **Telephone Number:** | | | | | |
| **Mr / Mrs / Miss / Ms / Other……..** | | | | | | | | | | **Work Number** | | | | | |
| **Address and Postcode** | | | | | | | | | | **Mobile Number:** | | | | | |
| **E-mail Address:** | | | | | |
| **Next of Kin:** | | | | | |
| **Next of Kin Contact Number:** | | | | | |
| **Date of Birth:** | | | | **Previous / Mother’s surname if different:** | | | | | | **Town & Country of Birth** | | | | | |
| **Marital Status:** |  | | | **Gender:** | | | **Male:** | **Female:** | | **Other residents of your home: please list names and age** | | | | | |
| **Occupation:** | | | | | | | | | |
| **Names & Ages of Children** | | | | | | | | | |
| **Housing**  **(Select one)** | | **House** | | **Maisonette** | | | **Flat** | **Mobile Home** | | **NHS Number (If Known)** | | | | | |
| **Previous Address** | | | | | | | | | | **Previous Postcode:** | | | | | |
| **Previous Doctor Telephone No.** | | | | | |
| **Previous Doctor Name & Address:** | | | | | | | | | | **Previous data released?** | | **Yes** | | | **No** |
| **If applicable, date you**  **first came to live in Britain:** | | | | | |
| **If returning from**  **Armed Forces:** | | | | **Your Service or Personnel Number** | | | | | | **Your Enlistment Date** | | | | | |
| **Your**  **height:** | | **Feet / inches** | | | **cm** | | | **Your**  **weight:** | | **Stones / lbs.** | | | **kg** | | |
|  | | | | | | | | | | | | | | | |
| **Your**  **Religion:** | | **C of E** | | **Catholic** | | | **Other Christian (state)** | | | **Buddhist** | **Hindu** | | | **Muslim** | |
| **Sikh** | | **Jewish** | | | **Jehovah’s Witness** | | | **No religion** | **Other religion (state)** | | | | |
|  | | | | | | | | | | | | | | | |
| **Your Ethnic Origin:**  **(select one)** | | | | **White (UK)**  **9i0** | | | | **White (Irish)**  **9i1%** | | | **White (Other)**  **9i2%** | | | | |
| **Caribbean**  **9i3** | | | | **African**  **9i4** | | | | **Asian 9i5** | | | **Other Mixed**  **Background 9i6%** | | | | |
| **Indian /**  **Brit Indian 9i7** | | | | **Pakistani /**  **Brit Pakistani 9i8** | | | | **Bangladeshi / Brit Bangladeshi 9i9** | | | **Other Asian**  **Background 9iA%** | | | | |
| **Other Black**  **Background** | | | | **Chinese**  **9iE** | | | | **Other**  **9iF%** | | | **Ethnic Category**  **not stated 9iG** | | | | |
|  | | | | | | | | | | | | | | | |
| **Your main or 1st language Spoken / Understood:**  **(select one)** | | | | **English** | | | **Hindi** | **Gujurati** | | **Urdu** | **Bengali /Sytheti** | | | **Punjabi** | |
| **Polish** | | **Ukrainian** | | **French** | | | **German** | **Spanish** | | **Other:**  **(Please**  **Specify)** | | | | | |
|  | | | | | | | | | | | | | | | |
| **Smoking, Alcohol Consumption and Exercise:** | | | | | | | | | | | | | | | |
| **Are you currently a smoker?** | | | | **Yes** | | | **No** | **Have you ever been a smoker?** | | | **Yes** | | | **No** | |
| **If so, how many cigarettes / cigars / tobacco do you smoke in a week?** | | | | | | |  | **How much alcohol do you drink in a week (Units)?**  *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)* | | | | | |  | |
| *If you are a smoker and want to stop, please ask for information about local smoking cessation services.* | | | | | | | |
| **How often do you exercise?** | | | | | **No. times per week** | | | | **Type(s) of exercise:** |  | | | | | |
|  | | | | | | | | | | | | | | | |
| **Your Medical Background:** | | | | | | | | | | | | | | | |
| **What illnesses have you had & When?** | | |  | | | | | | | | | | | | |
| **What operations have you had and When?** | | |  | | | | | | | | | | | | |
| **Do you have any medical problems at present? If so please include dates of diagnoses where possible** | | | **i.e. Asthma – 01.01.2006** | | | | | | | | | | | | |
| **Please list any tablets, medicines or other treatments you are currently taking:**  **(incl. dose + frequency)** | | |  | | | | | | | | | | | | |
| **Are you able to administer your own medicines?** | | | **Yes** | | | **No – please detail specific issues (e.g. swallowing, opening containers)** | | | | | | | | | |

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| **Are there any**  **serious diseases that affect your Parents, Brothers or Sisters**  **(tick all that apply)** | | | | **Diabetes** | | | **Heart Attack** | | | | **Heart attack under age of 60** | | | | **Bowel Cancer** | | | |
| **Breast Cancer** | | | | | | | **High Blood Pressure** | | | | **Asthma** | | | **Stroke** |
| **Thyroid Disorder** | | | | | | | **Any other important Family Illness?** | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **What immunisations have you had? (please tick all that apply)** | | **Diphtheria** | | | **Measles** | | | **German Measles** | | | | | **Tetanus** | | **Polio** | | | **MMR** |
| **Whooping Cough** | | | | | | **Pre-school booster** | | | | | **Triple vaccine (Diphtheria,**  **Tetanus & Pertussis) –**  **3 doses** | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Specific Needs:**  **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** | | | | | | | | | | | | | | | | | | |
| **Please state any Sensory Impairment you have**  **(i.e. Speech, Hearing, Sight):** | | | | | |  | | | | | | | | | | | | |
| **Are you an ‘Assistance Dog’ User?** | | | | | |  | | | | | | | | | | | | |
| **Please state any Physical disabilities you have:** | | | | | |  | | | | | | | | | | | | |
| **Please state any Mental disabilities you have:** | | | | | |  | | | | | | | | | | | | |
| **Please state any requirements you have to be able to access the Practice premises** | | | | | |  | | | | | | | | | | | | |
| **Please state any Religious or Cultural needs:** | | | | | |  | | | | | | | | | | | | |
| **Do you require the help of a Translator / Interpreter?** | | | | | |  | | | | | | | | | | | | |
| **Please state any specific nutritional requirements you have:** | | | | | |  | | | | | | | | | | | | |
| **Please state any allergies and sensitivities you have:** | | | | | |  | | | | | | | | | | | | |
| **Please state any phobias you have:** | | | | | |  | | | | | | | | | | | | |
| **If you are a Carer, please state the name / address / phone number of the person you care for:** | | | | | | **Person Cared For Contact Details:** | | | | | | | | | | | | |
| **If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.** | | | | | | **Carer Contact Details:** | | | | | | | | | | | | |
| **Signed: Date:** | | | | | | | | | | | | |
| **Do you have a “Living Will”**  **(a statement explaining what medical treatment you would not want in the future)?** | | | | | | **Yes / No** | | | | ***If “Yes”,***  ***can you please bring a written copy of it***  ***to your New Patient Consultation*** | | | | | | | | |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | | | | | | **Yes / No** | | | | **If “Yes”, please state their name / address / phone number:** | | | | | | | | |
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| **Accessible Information Standard**  **Do you require information to be provided in another form? Please tick below any options that are applicable to you:**   * **Uses a hearing loop** * **Uses voice amplifier to support communication** * **Braille** * **Requires written information in large font** * **Preferred method of communication: British Sign language** * **Uses sign language** * **Interpreter needed** | | | | | | | | | | | | | | | | | | |
| **Women only:** | | | | | | | | | | | | | | | | | | |
| **When was your last smear done?** | | | **Date** | | | | | **Was this at your**  **GP’s Surgery?** | | | | | **Yes** | | | | **NO** | |
| **What was the result**  **of the smear?** | | | | |  | | | | | | | | | | | | | |
| **Date of last mammogram**  **(if applicable):** | | | | | **Date** | | | | | **Method of contraception (if used):** | | | |  | | | | |
| **Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?** | | | | | | | | | | | | | **Yes** | | | | **NO** | |
|  | | | | | | | | | | | | | | | | | | |
| **Summary Care Records.**  **The NHS are changing the way your health information is stored and managed.**  **The NHS Summary Care record is an electronic record of important information about your health.**  **It will be available to health care staff providing your NHS Care. An information pack has been provided.** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Are you happy to have a Summary Care Record?** | | | | | **Yes** | | | | **No** | | | **More Time Required to decide:** | | | | | | |
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| **Patient Participation Group**  **The Practice is committed to improving the services we provide to our patients.**  **To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.**  **By expressing your interest, you will be helping us to plan ways of involving patients that suit you.**  **It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.**  **If you are interested in getting involved, please tick the box below and we will give you some more information or sign up via the website** | | | | | | | | | | | | | | | | | | |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the “Yes” Box)** | | | | | | | | | | | | | | | | **Yes** | | |
|  | | | | | | | | | | | | | | | | | | |
| **Patient**  **Signature:** |  | | | | | | | | | | **Signature on**  **behalf of Patient:** | | |  | | | | |

***For more information about the services we offer, please refer to your new patient pack  
 or see our website:***

[***www.acocksgreenmedicalcentre.org.uk***](http://www.acocksgreenmedicalcentre.org.uk)

***For Staff use only***

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Documents seen** | **Driving License** | **Tenancy agreement** | **Utility Bills** | **Passport** | | **Bank Statement** | |
| **Other (Please state)** |  | | | | | |
| **Staff Initials** | **Staff Signature** | | | **Date** | |
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