NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE NOTE YOU NEED TO RETURN THIS FORM IN PERSON WITH YOUR ID

Name (please print)				
Home Telephone Number Daytime contact number (if different)				
Address & Post Code				
Previous Address & Post Code				
Mobile Number				
E-mail				
Date of Birth				
Ethnic origin (please circle)	White British	Mixed Race	Bangladeshi	Black African
	White Other	Indian	Other Asian	Chinese
	White Irish	Pakistani	Black Caribbean	Other
Main spoken language				
Occupation				
Current / previous military service	Yes / No			
Previous GP/Address				
Next of kin / contact number				
Non Dispensing patients Please nominate your pharmacy				
Would you like to register for online services, Booking appointments, ordering prescriptions	Yes / No			
Do you agree to you and your child/children's **Summary Care Record(s)** (key information about current medications, allergies, adverse reactions) being accessed by doctors and nurses in the wider NHS if you need urgent or unplanned care?	Yes / No			

This short questionnaire is to help us to identify your immediate health needs and help you to prepare for your new patient health check. Please complete this form and return it to the receptionist.

Please note: Failure to attend the new patient health check could invalidate your registration.

Have you ever been a patient at this practice in the past? Yes / No

Please give details of the following:

1. **Lifestyle**

a) How much alcohol do you drink each week?

_____

b) Do you smoke?

- □ Never smoked
- □ Ex-smoker
- □ Current smoker Amount per day _____

c) How often do you exercise?

_____

2. **Current Illness:**

a) Do you have any current health problems? Yes / No

If yes, please provide details:

_____

b) Do you have any past illnesses, (including heart disease, diabetes, asthma, blood pressure or epilepsy)? Yes / No

If yes, please provide details:

_____

c) Have you had any previous operations or hospital admissions? Yes / No

If yes, please provide details:

_____

d) Is there any family history of cancer, diabetes, asthma, stroke, heart failure, heart Attack or epilepsy? Yes / No

If yes, please provide details:

_____

e) Do you take any regular medications/treatment,

(including contraception)? Yes / No

If yes, please bring a copy or your current medications or bring your tablets.

When is your next prescription for current medications due?

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f) Do you have any allergies? Yes / No

If yes, please provide details:

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3. Special requirements:

Do you have any special needs (e.g. mobility, hearing, vision)?

If yes, please provide details:

Are you housebound? Yes / No

Do you have a carer? Yes / No

Are you a carer? Yes / No

If yes, please provide details:

Thank you for your co-operation.

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Please return the completed form to the receptionist.