

HEATH LANE SURGERY

FOR OFFICE USE ONLY

Photo ID Address ID
Reception Nurses
Admin

New Patient Health Questionnaire

First Name: _____ Surname: _____

DOB: _____ Age: _____ Male/Female: _____

Address: _____

Postcode: _____

Telephone Numbers:

Home: _____

Mobile: _____ Work Number: _____

Email Address: _____ Occupation: _____

Are you or have you been a serving member of the: Army Royal Navy Royal Marines Royal Air Force If yes, which? & include ranking number _____

Are you the family associate of a past or present serving member of the armed forces? Yes No

Discharge from services date _____

Do you have any communication needs due to disability impairment or sensory loss to help us to make sure that you receive communication in a format that you can understand?

Yes No If Yes, please provide further details

Please list other residents of your home who are registered with us:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Next of kin: Name: _____ Relationship to you: _____

Next of kin address: _____

Telephone number: _____

Do you have a carer? Yes No Their contact details: _____

Do you consent for your carer to be informed about your medical care? Yes No

Are you a carer? Yes No If Yes, for whom? _____

ALL ABOUT YOU:

Ethnic Group: (Please Tick ✓)

- | | |
|--|---|
| <input type="checkbox"/> White British | <input type="checkbox"/> Indian |
| <input type="checkbox"/> White Irish | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> Any Other White Background | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Mixed White & Black Caribbean | <input type="checkbox"/> Any Other Asian background |
| <input type="checkbox"/> Mixed White & Black African | <input type="checkbox"/> Black Caribbean |
| <input type="checkbox"/> Mixed White & Asian | <input type="checkbox"/> Black African |
| <input type="checkbox"/> Any other Mixed Background | <input type="checkbox"/> Any other Black Background |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Any Other ethnic Group |

Language

Main spoken language: _____

Do you require an interpreter? Yes No

Height: _____ Weight: _____ Waist Measurement: _____

Blood Pressure: 1st Reading ____/____ 2nd Reading ____/____

Allergies/ Allergies to Medication: Yes No (If yes please specify)

Current Medications: Yes No (If yes please specify) _____

Nominated Pharmacy (EPS) _____

(Where would you like your prescription sent to)

Lifestyle

Exercise: (Please Tick ✓) Light Moderate Heavy Unable
Diet: (Please Tick ✓) Vegetarian Vegan Normal Diabetic

If applicable

Date of last smear _____ Result _____

Date of last mammogram _____ Result _____

Do you use any form of contraception? Yes No (if yes, please specify)

Any previous illnesses, operations or medical impairments

Please tell us about your smoking habits: Do you smoke? Yes No

If Yes, what do you primarily smoke: Cigarettes / Cigar / Pipe (please circle)












How many do you smoke a day? _____

Would you like advice on quitting? Yes No

Are You an Ex-Smoker? Yes No When did you quit? _____

How many did you used to smoke a day? _____

Please tell us about your alcohol consumption:

1 UNIT	1.5 UNITS	2 UNITS		3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%		 Large glass of wine (250ml) 12.5%		

Alcohol History: Number of units per week? _____

Teetotal

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Have you ever had any of the following conditions?

	✓			✓	
Epilepsy		Year	DVT		Year
High Blood Pressure		Year	Mental Illness (inc Depression)		Year
Heart Attack		Year	Diabetes (Type 1 or Type 2)		Year
Angina (stable/unstable)		Year	Asthma		Year
Stroke		Year	COPD		Year
Transient Ischaemic Attack		Year	Osteoporosis		Year
Cancer		Year	Peripheral Vascular Disease		Year
Rheumatoid Arthritis		Year	Thyroid Disorder		Year

Do you have family history of any of the following?

	✓			✓	
High Blood Pressure		Who	DVT / Pulmonary Embolism		Who
Ischaemic Heart Disease Diagnosed aged >60yrs		Who	Breast Cancer		Who
Ischaemic Heart Disease Diagnosed aged <60yrs		Who	Any Cancer Specify type:		Who
Raised Cholesterol		Who	Thyroid Disorder		Who
Stroke		Who	Diabetes		Who
Asthma		Who	COPD		Who
Osteoporosis		Who	Mental Health Disorder		Who
Epilepsy		Who	Kidney Disease		Who

Please record any additional information about you that you think is important for us to know?

Are you looking after someone else's child? Yes No

If Yes, under what arrangements:

Section 20-Voluntary Care Interim Care Order Care Order

Child arrangement order/Residence Order Special Guardianship order Placed for adoption

Private arrangement/Private Fostering/informal arrangement

(Please note you have a duty to notify social care of this arrangement)

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

More information can be found by visiting:

www.nhscarerecords.nhs.uk

Tick this box

If you wish to opt out of the SCR

Enhanced Data Sharing Module (eDSM)

Whilst the SCR mentioned shares a very small portion of your medical record across the whole NHS, the eDSM shares a much fuller view of your records but with local NHS providers – and only when you give explicit consent at the point of care.

Tick this box

If you wish to opt out of the eDSM

Thank you for completing this form. If you would like a health check with the nurse please make an appointment at Reception.

Date form completed _____