

**CONFIDENTIAL****HEALTH QUESTIONNAIRE FOR NEW PATIENTS****To The Patient:**

*To register with the Practice please complete this questionnaire as fully as possible and bring it with you when you attend for your 'new patient' appointment with the practice nurse. The information will help us make an initial assessment of your health and future treatment.*

Name: Telephone Home:

Address:

Mobile:

Post code:

Date of Birth:

Work:

Your Email address:

Marital Status: Single / Married / Cohabiting / Separated / Divorced / Widowed.

Occupation / School / College:

Does your job bring you into contact with dust, fumes, loud noise, repetitive tasks eg. Lifting / typing? If so please give details:

**Personal Medical History**

*Please detail any serious or chronic illnesses, operations or disabilities, brief details and approximate year:-*

Current: conditons needing treatment (eg. Asthma, Eczema, Diabetes, Thyroid, Blood Pressure, Heart or Lung conditions):

Previous: Significant conditions needing treatment (eg. Heart attack, epilepsy, asthma, stroke, appendix, cancer, major injuries, broken bones etc.

Hospital Admissions:

Operations: (eg gallbladder, appendix, hysterectomy, caesarean section.)

Are you allergic to any medicines or plasters? (eg. causing a rash or breathing problems)

Have you had a severe allergic reaction to anything else? (eg. bee sting, nuts, eggs etc.)

Do you take any drugs, medicines or contraceptive pills?  
Please list these and the dose:

**Family Medical History**

Have any of your close relatives (parents, brothers, sisters) suffered from any significant medical problems eg. heart disease, diabetes, cancer (include site of cancer), high blood pressure, high cholesterol levels, Stroke especially below the age of 65 years, thyroid, m/s, alzhimers or other?

Relative	Any relevant conditions	Still Alive?	If dead, please give age & cause of death
Mum		YES / NO	
Dad		YES / NO	
Brothers		YES / NO	
Sisters		YES / NO	

**Lifestyle**

**Smoking**

Do you currently smoke? Yes / No

How many cigarettes / cigars / ozs tobacco do you smoke a day?

How old were you when you started smoking?

Would you like advice on stopping? Yes / No

**Ex- Smokers**

Have you ever smoked? Yes / No

How many cigarettes / cigars / ozs tobacco did you smoke a day?

When did you give up?

**Passive Smoking**

Are you exposed to smoke at work? Yes / No At Home? Yes / No

<b>Alcohol</b>	
<i>For the following questions please circle the answer which best applies</i>	
<i>1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits</i>	
<b>Men:</b> How often do you have EIGHT or more drinks on one occasion?	
<b>Women:</b> How often do you have SIX or more drinks on one occasion?	
<i>Never / Less than monthly / Monthly / Weekly / Daily or Almost Daily</i>	
How often during that last year have you been unable to remember what happened the night before because you had been drinking?	
<i>Never / Less than monthly / Monthly / Weekly / Daily or Almost Daily</i>	
How often during that last year have you failed to do what was normally expected of you because of drinking?	
<i>Never / Less than monthly / Monthly / Weekly / Daily or Almost Daily</i>	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	
<i>No / Yes on one occasion / Yes on more than one occasion</i>	
<b>Diet</b>	
Do you add salt to your food after cooking?	Yes / No
Do you have a varied diet including milk, meat, vegetables & Fruit	Yes / No
Has your Cholesterol been checked in the last 2 years?	Yes / No
<b>Exercise</b>	
Do you take regular exercise?	Yes / No
If yes, what sort of exercise?	
How many times per week do you exercise?	

<b>Vaccinations / Immunisations</b>	
Have you ever had a full course of Tetanus or Polio vaccines?	Yes / No
Dates of Triple / polio / HIB:	
Dates of MMR:	
Date of last Tetanus:	
<b>Carers</b>	
Do you need/have anyone who looks after you or you daily needs as a Carer?	Yes / No
If Yes, would you like them to deal with your health affairs here? (the receptionist can help with these arrangements)	Yes / No
Do you care for anyone else?	Yes / No
If Yes, ask the receptionist about Carers support	

<b>Women only</b>		
Have you had a cervical smear from your GP in the last 5 years?	Yes / No	Date:
Have you had a cervical smear since then at a clinic / hospital / other (delete)?	Yes / No	Date:
Have you ever had any abnormal smears?	Yes / No	Date:

Have you had a hysterectomy? If so, were both ovaries removed?	Yes / No Yes / No	Date:
Have you had a mammogram in the last 5 years? Was it normal?	Yes / No Yes / No	Date:
Have you ever been pregnant?  Please list any pregnancies along with the type of delivery? eg. Caesarean Section, forceps, Ventouse, Normal	Yes / No	Dates:

*Nurses use only below*

<b>Examination</b>	
Height:	Weight:
BMI:	Urinalysis:
Blood pressure:	Peak Flow Reading:

*Revised: JML June 2009*