

Health questionnaire for new patients

your full name



.....

female male prefer not to say

your address

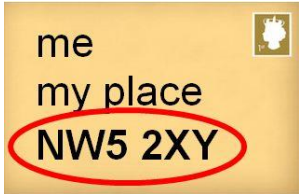


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.....

.....

your postcode



.....

your phone number(s)



home.....

mobile.....

work.....

your date of birth



.....

married or single



I am married.....

I have a partner (not married).....

I am single.....

your sexuality



straight/heterosexual.....

gay/lesbian.....

bisexual.....

other.....

I'm not sure.....

date you came to live in UK



Date
?

.....

**name and address of your last GP
if you have registered before**

My GP



GP Surgery
Street
Postcode



.....
.....
.....
.....
.....

do you have a job?



yes

no

my job is.....

how much do you weigh?



kg

stone

pounds

how tall are you?



cm

feet

inches

your blood pressure



.....

your place of birth (town | country)



.....

languages you speak



your first language.....

other language(s).....

.....

your ethnicity (where your family is from)



.....

do you need an interpreter?



yes

no

if you are under 16 years old



name of your parent(s) or carer(s)

.....

their relationship to you



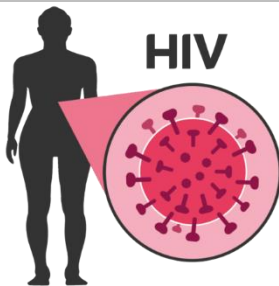
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the name of your school



.....

if you are over 16 years old



you can have an HIV test – would you like to have one?

yes

no

If yes, please let reception know and tell them if you would prefer to have the test at the Royal Free or the Whittington Hospital

- They will fill out a **blood test form** for you
- Take it the hospital you've chosen between **9am** and **4.30pm**, **Monday** to **Friday**, and they will take blood for the test

if you are over 16 years old



you can have a sexual health test – would you like to have one?

yes no

If yes, please ask reception to book this with the nurse

if you are over 75 years old



you can have a health check – would you like to have one?

yes no

If yes, please ask reception to book this with the doctor and health care assistant (HCA)

next of kin details



name of your next of kin

.....

their contact details

.....

their relationship to you



.....

do you smoke?

yes no

if yes, how many do you smoke?



cigarettes per day.....

cigars per day.....

other (e.g. pipe).....

at what age did you start smoking?

 years old

ex-smokers

at what age did you stop smoking?

 years old

how many did you smoke per day?



.....

passive smoking

do people smoke around you?

at work yes no at home yes no

diet

do you add salt to your food after cooking?



yes

no

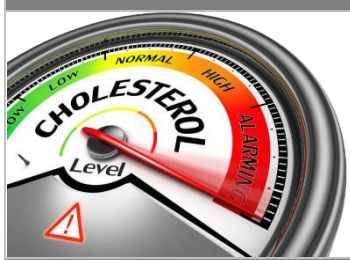
do you have a varied diet that includes milk, meat, vegetables and fruit?



yes

no

has your cholesterol been checked in the last 2 years?



yes

no

exercise

do you take regular exercise?



yes

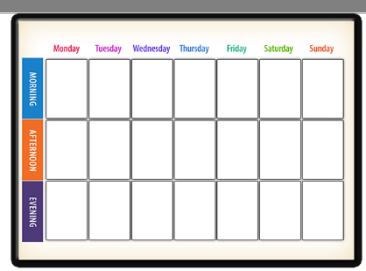
no

if yes, what kind of exercise?



.....

how many times per week?



.....

**allergies – are you allergic to anything?
(for example, food, medicines, bee stings)**



yes

no

if yes, please give details below



.....

.....

.....

.....

**alcohol
alcohol unit information**



1 pint of beer or lager or cider = **2 units**



1 alcopop or 1 can of lager = **1½ units**



1 glass of wine (175ml) = **2 units**



1 single measure of spirits = **1 unit**

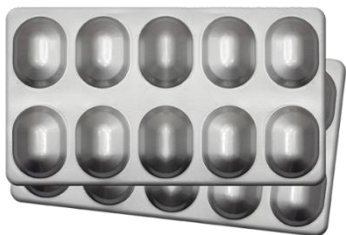


1 bottle of wine = **9 units**

follow along the row to work out your score for each question and add this number to the last column	working out your score					your score
	0	1	2	3	4	
how often do you have a drink that has alcohol in it?	never	once a month or less	2-4 times per month	2-3 times per week	4+ times per week	
how many alcoholic drinks do you have on a normal day when you are drinking?	1-2	3-4	5-6	7-8	10+	
how often do you have 6 or more alcoholic drinks on 1 occasion?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
how often in the last year have you found that you couldn't stop drinking once you'd started?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
how often in the last year have you not managed to do what you were supposed to do because of drinking?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
has a family member/friend/doctor or worker been worried about your drinking or asked you to drink less?	no		yes but not in the last year		yes, during the last year	

if your score is **5 or more**, you may be drinking too much alcohol

**please tell us about any medicines you
take (whether or not these are prescribed)**



name of medicine.....

dosage (amount you take).....



name of medicine.....

dosage.....

name of medicine.....

dosage.....

name of medicine.....

dosage.....

name of medicine.....

dosage.....

female patients only
date of your most recent cervical smear



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where did you have the smear test done?



.....

what was the result of the smear test?



normal

abnormal

pregnancy - please tell us about any complications, miscarriages, terminations



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what contraception are you using now?



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carers – do you have or need a carer?



yes

no

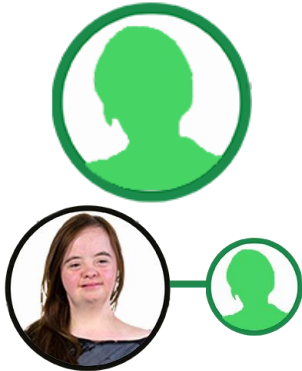
**if yes, would you like your carer to deal with your health matters at the GP's?
(the receptionist can help arrange this)**



yes

no

are you a carer for anyone else?

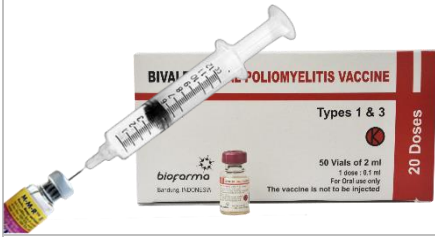


yes

no

if yes, ask the receptionist about support for carers

record of vaccination dates



type of vaccination	1st	2nd	3rd	booster
Diphtheria/Polio/HIB				
Meningitis C				
BCG				
MMR				

if MMR was given separately, please list details below

Measles				
Mumps				
Rubella (German Measles)				
Tetanus				
Typhoid				
Yellow Fever				
Cholera				
Hepatitis A				
Hepatitis B				
Hepatitis C				

please tell us about any other vaccinations below

your medical history
have you ever been admitted to hospital?



yes no

what were you in hospital for?



.....

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.....

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.....

please tell us about any treatment you've had for chronic (long-term) conditions



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X-rays, scans, ultrasound, mammogram
Please give dates below



X-rays

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MRI scans

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CT scans

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Mammogram

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Ultrasound

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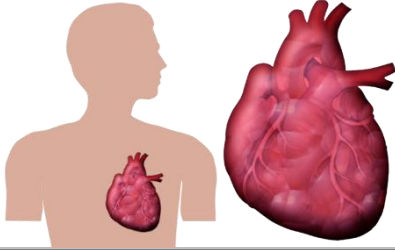
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your family history

is there any of the following in your family (mother, father, sister, brother) before the age of 65?

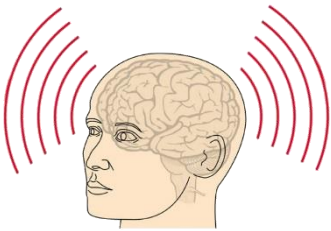
heart disease (heart attacks, angina)



yes no

which family member?.....

stroke



yes no

which family member?.....

asthma



yes no

which family member?.....

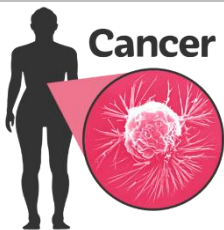
diabetes



yes no

which family member?.....

cancer



yes no

which family member?.....

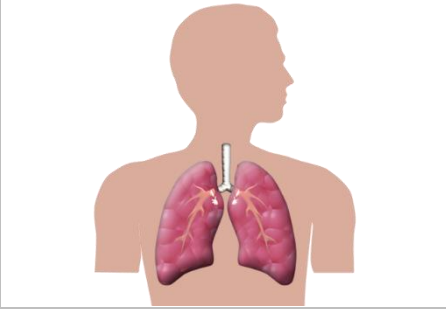
high blood pressure



yes no

which family member?.....

tuberculosis (TB)



yes no

which family member?.....

other serious illness



yes no

which family member?.....

what illness?.....

Please sign and date this form below

signed.....

date.....

S Yourname



Thank you for filling in this health questionnaire

- Please book an appointment for a **new patient health check** with the health care assistant (HCA)
- After you have registered, please ask reception to give you patient **online access** details