New Patient Health Questionnaire for ALL

Please complete any areas with *

Your Contact Details*

Title

Mr □ Mrs □ Miss □ Ms □ Other □ Surname

Date of Birth First Names

Occupation Previous Surnames

Home Address

Postcode:

We use text (SMS messaging) and email to send reminders of appointments and to contact you about results if needed. ***By giving your mobile number and email address you are giving us consent to use them for health purposes.***

Email: **Mobile:**

Please provide an email address and mobile number where possible

Person filling in the form if not the patient:

Name and relationship to patient:…… / ……..

- For children and young people under 12 years of age we will use parent's mobile number for appointment reminders etc.
- For children and young people aged 12 years+ we will need to discuss this with them before adding theirs or a parents mobile onto the system.

If a child school aged what school do they attend?:……..

What is your first language?

Ethnic Group*

White	British	□	Irish	□	Other	□ Please State:……...
Black	Caribbean	□	African	□	Other	□ Please State:……...
Asian	Indian	□	Pakistani	□	Chinese	□ Other □ Please State:…….
Mixed	White+Black	□	Caribbean	White + Black African □		
	White + Asian	□	Other □	Please State:……		

Have you ever suffered from? (circle as appropriate)*

Heart Attack/Angina	Yes / No	High Blood Pressure	Yes / No
COPD	Yes / No	Kidney Disease	Yes / No
Stroke/TIA	Yes / No	Diabetes	Yes / No
Rheumatoid Arthritis	Yes / No	Do you take Thyroxine	Yes / No

Do you currently have treatment for Asthma Yes / No

Do you have a learning disability? (If yes, please give details) Yes/No

Are you registered disabled?* (If yes, please give details) Yes / No

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Are you allergic to any medicines and if so, which? Yes / No

Are you on a repeat medication? Yes / No We will need a list of your repeat prescription list.

Have you ever suffered from?* (circle as appropriate)

Anxiety	Yes / No	Depression	Yes / No
OCD	Yes / No	Bipolar Disorder	Yes / No

Are you still on medication or treatment for this: Yes / No

Do you have any other mental health issues?* (If yes please give details)

Carers*

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

Are you a Military Veteran Yes / No (Code 13Ji)

Smoking*

Do you smoke? Yes / No

If 'No', have you ever smoked? Yes / No

If you do currently smoke, how much do you smoke per week?

Light -1-9 per day □ Moderate 10-19 per day □ Heavy 20-39 per day □ Vaping □ Other(please state) □

Would you like advice on giving up smoking? Yes / No

Alcohol* *1 unit is approx = 1/2 pint of beer or 1 glass of wine or 1 single spirits*

Do you drink alcohol each day?: Yes / No

How many units do you typically have each week?: …….

Patient Participation Group

Would you like to help us improve our services by joining our Patient Participation Group (PPG)?

Attend meetings Yes / No

Join the Reference Group and receive information emails about changes to the surgery Yes / No

If applicable what is your previous address?

Number & Street:

Town/City:

County:

Postcode:

What is your previous GP practice?

Name:

Address:

Are you from abroad?

If yes:

What date did you arrive back in the UK?

What was your address when you were living there?

Number & Street name:

Town/City:

Post/Zip code:

Next of Kin

Name:

Emergency contact details:

Do you consent for your prescriptions to be sent electronically?

Name and Address of pharmacy?

PLEASE NOW GIVE THIS FORM TO RECEPTION – THANK YOU