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NEW PATIENT HEALTH QUESTIONNAIRE (ADULTS)

TITLE – Mr / Mrs / Miss / ..... SURNAME……

FIRST NAME(S)……..

DATE OF BIRTH (dd/mm/yyyy) ……..... MALE / FEMALE

MARITAL STATUS…….....
(eg Married/Single/Widowed)

TELEPHONE NUMBER (Home)…… (Mobile) ……

EMAIL ADDRESS……..
□ Please tick if you **DO NOT** wish to be contacted by EMAIL
□ Please tick if you **DO NOT** wish to be contacted by SMS TEXT MESSAGE – we will text to remind you of an appointment, or if we need you to contact the surgery for any reason.
(we do not share this information with any other organisation)

OCCUPATION……..

HEIGHT…… WEIGHT……..

NEXT OF KIN - Name……

Address……

Phone no…… Relation to the patient……

PLEASE ADVISE WHICH ONE OF THE FOLLOWING CHEMISTS YOU WOULD LIKE YOUR REPEAT PRESCRIPTION(S) TO BE SENT: (Please tick the appropriate box)
**** If no chemist is selected, prescriptions will default to 'Williams Southgate (next door to the surgery)' ****

□ Boots County Mall	□ Asda	□ Kamsons Southgate	□ Kamsons Broadfield
□ Lloyds Tilgate	□ Sainsbury's	□ Williams Southgate (Next door)	□ Williams Furnace Green

WOMEN ONLY: AGES 25-64 (The screening intervals are: Age 25-49 3 yearly. Age 50-64 5 yearly)

- IF YOU HAVE **NOT** HAD A SMEAR IN THE LAST 3 OR 5 YEARS IS THERE A REASON?
  ……..
- DO YOU WISH TO BE REMOVED FROM THE NHS CERVICAL SCREENING PROGRAMME?
  YES / NO
- If you have recently arrived into the UK, please make an appointment for a cervical smear or if you wish to be removed from the NHS Cervical Screening Programme, please ask at reception for an exemption form.
- WHAT FORM OF CONTRACEPTION, IF ANY, DO YOU USE? ……
  WOULD YOU LIKE CONTRACEPTION ADVICE? YES / NO
- ARE YOU CURRENTLY PREGNANT? YES/NO
  HOW MANY WEEKS?.....EXPECTED DATE OF DELIVERY……

HAVE YOU EVER SMOKED? YES / NO
IF YES AND HAVE GIVEN UP. PLEASE GIVE THE DATE……..
IF YES AND CURRENTLY SMOKING. WHAT DO YOU SMOKE?
Cigarettes / Cigars / Pipe / Rolled Tobacco (please delete as appropriate)
How many times a day do you smoke? …… (per day)
WE DO OFFER SMOKING CESSATION ADVICE CLINIC AT THE SURGERY – PLEASE ASK AT RECEPTION FOR DETAILS

DO YOU DRINK ANY ALCOHOL? YES / NO
IF **YES** ON AVERAGE HOW MANY UNITS PER WEEK DO YOU CONSUME? ……
(1 pint = 2 units 1 shot of spirit = 1 unit 1 glass of wine = 1.5 units)

Please tick the appropriate box.

MEN: HOW OFTEN DO YOU HAVE **EIGHT** OR MORE DRINKS ON ONE OCCASION?
WOMEN: HOW OFTEN DO YOU HAVE **SIX** OR MORE DRINKS ON ONE OCCASION?
□Never □Less then monthly □Monthly
□Weekly □Daily or almost daily

HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER THE NIGHT BEFORE BECAUSE YOU HAD A DRINK?
□Never □Less then monthly □Monthly
□Weekly □Daily or almost daily

HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT IS NORMALLY EXPECTED OF YOU BECAUSE OF DRINKING?
□Never □Less then monthly □Monthly
□Weekly □Daily or almost daily

IN THE LAST YEAR HAS A RELATIVE, FRIEND, DOCTOR OR ANOTHER HEALTH WORKER BEEN CONCERNED ABOUT YOUR DRINKING AND SUGGESTED YOU CUT DOWN?
□No □Yes, on occasion □Yes, on more than one occasion

Due to government policy, we are obliged to ask you the following:
PLEASE STATE YOUR FIRST SPOKEN LANGUAGE……..
English language spoken? YES / NO

WHAT IS YOUR ETHNIC GROUP? (Please only choose ONE and tick the appropriate box)

WHITE	BLACK OR BLACK BRITISH	EASTERN ASIAN
□British	□Caribbean	□Chinese
□European	□African	□Vietnamese
MIXED	ASIAN OR ASIAN BRITISH	MIDDLE EASTERN
□White & Black Caribbean	□Indian	□Arabic
□White & Black African	□Pakistani	□Iranian
□White & Asian	□Bangladeshi	□Turkish

□ ANY OTHER GROUP NOT STATED ABOVE……..……
□ I DO NOT WISH TO STATE MY ETHNIC GROUP

PLEASE ADVISE ALLERGIES TO MEDICATION OR ANY OTHER:……

……

PLEASE STATE ANY MEDICAL HISTORY I.E. ILLNESSES, OPERATIONS WITH DATES IF POSSIBLE THAT **YOU** FEEL THE PRACTICE SHOULD BE AWARE OF: ……

……

CURRENT MEDICATION (Do you take any medication that you obtain on prescription from your Doctor)

……

……..……

DOES A FAMILY MEMBER SUFFER FROM ANY OF THE FOLLOWING?

□ Asthma Specify family member(s)…….

□ Diabetes Specify family member(s)……..……..

□ Heart Disease (Under 60 years old) Specify family member(s)……

□ Heart disease (Over 60 years old) Specify family member(s)……

□ Stroke Specify family member(s)…….

IF ANY IMMEDIATE FAMILY MEMBER HAS DIED, PLEASE SPECIFY, AGE AND CAUSE OF DEATH

…… ……..

ARE YOU A CARER? YES / NO

(Do you look after a partner, relative, child, neighbour or friend who has a long term illness or is disabled or frail)

IF YES PLEASE STATE RELATIONSHIP AND DATE OF COMMENCEMENT

……..……

Does the person you care for have dementia? YES / NO

(There is a carer support service to provide local and national information. Please ask at reception).

(eDSM) **SHARING OF YOUR MEDICAL RECORDS BETWEEN HEALTH PROFESSIONALS.**

In order to provide the best and safest health care it is possible to allow clinicians caring for you to view medical information recorded by other healthcare services. For example it may be useful for your GP to be able to read information recorded by a district nurse to monitor your care and make a more informed decision when planning how best to treat you.

Can I refuse to share? Yes, you have the right to choose which services can share information or view shared information and you can change your mind at any time. PLEASE TICK TO REFUSE TO SHARE □

If I agree to share, who can view my information? Only health professionals who are currently involved in your health care and you have given consent to view can see information in the shared record. PLEASE TICK TO AGREE TO SHARE □

Can I hide specific entries on my record while sharing the rest of my information? Yes. If there is some information you do not wish to be shared, ask your health professional not to share that information.

(SCR) **SUMMARY CARE RECORD – your emergency care summary**

Your Summary Care Record will be available to authorized healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have **an accident or become ill,** healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice, please tick one of the following:-

- □ **Yes I would like a summary care record** – you do not need to do anything and a Summary Care Record will be created for you
- □ **No, I do not want a Summary Care Record** – please ask at reception for an opt-out form, complete the form and hand it back to a receptionist

Please ask at reception for more information regarding Record Sharing or Summary Care Records.