Queens Bower Surgery New Patient Questionnaire

This document does NOT automatically register you at the surgery

Health Questionnaire

PLEASE COMPLETE CLEARLY IN BLOCK LETTERS.
All information given on this form is kept strictly confidential and revealed to no one without your permission

ABOUT YOURSELF

SURNAME _____ **(Family Name)**

OTHER NAMES _____

DATE of BIRTH _____ **(month) (day) (year)**

PHONE NUMBER _____
_____

SEX **Male / Female**

CONSENT TO SMS TEXT **YES / NO**

CONSENT TO SHARE THE SHARED CARE RECORD (This is in the main about sharing drugs and allergies with other health providers e.g. casualty)

YES / NO

NEXT OF KIN (relationship) _____

_____

(contact details) _____

NATIONALITY _____

FIRST LANGUAGE _____

ARE YOU : **BRITISH ☐ FROM EU ☐ ASYLUM SEEKER ☐ REFUGEE☐ PERMANENT RESIDENT STATUS ☐**

(if an asylum seeker please notify us of changes)

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ETHNICITY

How would you describe your ethnic group :

A : White À British À Irish À Any other White background _____

B : Mixed

À White and Black Caribbean À White and Black African

À White and Asian À Any other mixed background _____

C : Asian or Asian British

À Indian À Pakistani À Bangladeshi

À Any other Asian background _____

D : Black or Black British

À Caribbean À African À Any other Black background _____

E : Chinese or other ethnic group

À Chinese

À Any other _____

À Not stated

Are you a carer ? Yes/No

You are a carer if you look after a friend, relative or disabled child who needs support to live at home.

YOUR CURRENT HEALTH
PAST MEDICAL HISTORY

Diabetes	☐	**Blood Pressure**	☐	**Heart Attack**	☐
Stroke	☐	**Smoker**	☐	**Non-Smoker**	☐
Asthma	☐	**Eczema**	☐	**Epilepsy**	☐
Hearing Problems	☐	**Seeing problems**	☐	**Mobility Problems**	☐
TB	☐	**HIV**	☐	**Hepatitis B**	☐

Any other conditions or operations? **None** ☐

_____

_____

_____

_____

_____

Any allergies to drugs or other materials? **None** ☐

_____

_____

Any current medication/treatment (including contraceptive pill?)

None ☐

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Please provide your repeat prescription slip

_____
_____
_____
_____

What is your height? _____ **(m)** _____ **(ft inches)**
Do you currently smoke? **(Yes)** **(No)**

How many per day? **<1 □ 1-9 □ 10-19 □ 20-39 □ >40 □**
What is your weight?

FAMILY HISTORY **If any significant medical events have affected your family, please state which relative has been affected and the nature of the problem.**

Diabetes □ Asthma □ Blood Pressure □ Heart Attacks □ Strokes □

Has a very close relative suffered from heart disease or stroke under the age of 55 years? **(Yes) (No)**
If "Yes", please tell the doctor or nurse to discuss a cholesterol test.

Sharing Information

A lot of providing good care is about knowledge of underlying conditions and knowing the management by the practice or us knowing about the care others are providing to you. Computer systems are starting to enable information to be shared. Overall sharing information allows quicker better quality care. You can change your mind at any time.

Do you give consent to the sharing of electronic data recorded by others with us, so that we can care for you better ?

YES / NO

Do you give consent to the sharing of data recorded here with any other organisations that may care for you ?

YES / NO

Contacting you

Contacting you by text message, email and other electronic means can help us to look after you.

We may use this to send you reminders of appointments, vaccinations due, or smears, regarding blood or results, or regarding the booking of appointments.

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Please realise that it is important for you to keep your details up to date.

Are you happy for us to contact you by

Text message **YES / No**
Email **YES / No**
Email address _____

Females only

Smear

When did you have your last smear ? **N/A ☐** **Date** _____
Was the result ? **Normal ☐ Borderline ☐ Abnormal ☐**
Was it done in this country ? **Yes ☐ No ☐**
Was it done by your : **GP ☐ Clinic ☐**

Do you have a coil fitted ? **Yes ☐ No ☐**

Do you drink alcohol? **(Yes)** **(No)**

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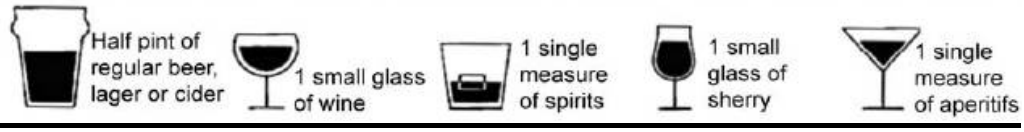
This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

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Immunisations

Please enter dates if known

	1st	2nd	3rd	Booster
DTP	2mnth	3mnth	4mnth	DT☐DTP☐
Hib	"	"	"	
Polio	"	"	"	
"Combined"	"	"	"	DTP+polio☐
Men C	"	"	"	X
MMR	12-18mnth	X	X	3.5-5yr
Heaf test				
BCG		X	X	
Hep A				
Hep B				
Typhoid				

Signature : _____ Date : _____

Please note as the main GP is Dr T Arya is your named GP.

For Medical Staff Only

BP _____ **HS** _____

PF _____

SPIROMETRY **FEV1** _____ **FVC** _____

INHALER TECHNIQUE **SHOWN** ☐ **GOOD TECHNIQUE** ☐

URINE TEST:

NITRITES ☐ **LEU** ☐ **BLOOD** ☐ **GLU** ☐ **KET** ☐