

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Introduction

This questionnaire can be used to capture data for new patient registrations. It will also help to establish a base-line view of the patient's lifestyle and will assist the nurse/doctor in carrying out a new patient health check. The information provided will also assist in the identification of "at risk" patients and focus care advice on at-risk areas.

Related Information: Ethnic Origin Monitoring procedure [*]
 New Patient Registration Policy [*]

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NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

Surname: Forename(s): Date of Birth:

Marital status: Previous Surname:

Address:

..... Postcode:

Home tel: Mobile:

Email address:

Occupation:

Weight (approx): Height:

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with news about the practice

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with advice about your health and/or appointment reminders

Date of completion of this form:

Ethnic Origin

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background, please state:

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background, please state:

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background, please state:

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	Any other black background, please state:

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other, please state:

First language:

Smoking

Do you smoke? *Yes / No*

If Yes, how many...: Cigarettes per day Ounces of tobacco per day

How old were you when you started smoking?

Ex-Smokers

How old were you when you stopped smoking?

How much did you smoke per day?

Passive Smoking

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

Alcohol

For the following questions please circle the answer that best applies:

One drink = 1/2 pint of beer/one glass of wine/one single measure of spirits

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 than monthly Monthly Weekly Daily/Almost Daily

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily/Almost Daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily/Almost Daily

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?

Yes No

Diet

Do you add salt to your food after cooking? Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

Has your cholesterol been checked in the last two years? Yes / No

Exercise

Do you take regular exercise? Yes / No

If yes, what sort of exercise?

How many minutes do you typically spend exercising per session?

How many times do you exercise per week?

Family History

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

Heart Disease (e.g. heart attacks, angina) *Yes / No* which family member?

Stroke *Yes / No* which family member?

Cancer *Yes / No* which family member?

Site of cancer?

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug:

Dosage:

Name of drug:

Dosage:

Name of drug:

Dosage:

Allergies

Are you allergic to any substances, including medication or foods? *Yes / No*

If Yes, please give details:

.....
.....

Past Medical History

Please give details of any hospital treatment as an in-patient:

.....

Please give details of any treatment for any chronic medical conditions:

.....

Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound:

.....

Immunisations

Dates of triple/polio/HIB:

Dates of MMR:

Date of last Tetanus:

Female Patients

Date of most recent cervical smear:

Result of most recent smear:

Please give details of any complications in pregnancy:

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Carers

Does someone look after you? Or do you need / have anyone who looks after you or your daily needs as a Carer? *Yes / No*

If Yes, would you like them to deal with your health affairs here? *Yes / No*

The receptionist can help with these arrangements

Do you look after someone else? *Yes / No*

If Yes, please ask the receptionist about Carers support

General

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.