New Patient Health Questionnaire for Adults

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Patient Details

Title: Surname: Previous Surname/s:	First Names:	Date of Birth:
Home Address: Postcode:	Home Tel: Work: Mobile:	First Language: Preferred form of contact: (please circle) Text Email Letter
	Email Address:	☐ Opt in for online access (Please tick if you would like access to your medical records online)
Consent for Text messaging service: Please tick ☐ Yes ☐ No	We operate using EPS (Electronic Prescription Service). All prescriptions will be sent electronically from the practice to your nominated Pharmacy. **Please nominate a pharmacy to receive your prescriptions:**	

Name & Address of Previous GP:			
Next Of Kin:	Name:	Telephone:	Relationship:

Do you have a carer (If yes please give details) ☐ Yes ☐ No	Details :
Are you a carer (If yes please give details of the person you care for) ☐ Yes ☐ No	Details :

Ethnic origin

White	Black	Asian	Chinese	Mixed	Other	Decline
☐	☐	☐	☐	☐	☐	☐

Proof of Identify and Address Provider

☐ **Birth Certificate**	☐ **Passport**	☐ **Hospital Letter/GP Letter**
☐ **Driving Licence**	☐ **Utility bill**	☐ **Solicitors letter**
☐ **Tax credit form**	☐ **Tenancy Agreement**	☐ **Other (Please state)**

Please provide 2 of the above (1 must be photo identification)

Medical Information

Please list any serious illnesses/operations/accidents/disabilities (for women- Any pregnancy related problems)and the year they took place

Have you ever suffered from any of the following medical conditions (please tick)

Heart Disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Eczema/Hayfever	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No

Do you have any Allergies/ (if yes please state what they are)

- ☐ **Yes** ______________________
- ☐ **No**

Any family history of the following medical conditions (please say who e.g Father, Mother, Brother, Sister etc next to the condition)

- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Asthma
- ☐ Other ______________

List of Medication (or attach a copy of your repeat prescription)

Are you registered disabled? (if yes please give details) ☐ **Yes** ☐ **No**	**Details**

Smoking information

Do you Smoke?	☐ Yes	☐ No
If 'No' have you ever smoked?	☐ Yes Date Stopped	☐ No
If 'Yes' how many cigarettes/cigars or ounces of tobacco per week ?		
If you are a current smoker would you be interested in smoking cessation advice?	☐ Yes	☐ No

General information

Height :		Do you exercise? If yes how often?
Weight :		Do you eat a special diet? If yes what type?

Women Only

Have you ever had a smear? (If yes please state when and result if known)	☐ Yes	☐ No	Details:
Hysterectomy information and date if applicable	Details:		
Contraception information if used	Details :		
Are you currently pregnant	☐ Yes How many weeks?	☐ No	

Summary Care record

Summary care records are to improve the safety and quality of patient care. Because the summary care record is an electronic record it will give healthcare staff faster, easier access to essential information about you to help provide you with safe treatment when you need care in an emergency or when your GP medical centre is closed.

If you would like to have a summary care record in place that's can be assessed by healthcare staff please tick the box

I wish to have a summary care record ☐

I do not wish to have a summary care record (please compete the opt-out form attached) ☐

I believe all the information in this new patient health questionnaire to be accurate and correct to the best of my knowledge. Please sign and date below.

Signature: ____________________

Date: ____________________