**NEW PATIENT QUESTIONNAIRE**

**Please complete in CAPITAL letters and tick the boxes**

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| **First Name :** |  | **Surname** : |  |
| **Date of Birth :** |  |
| **Ethnic Origin :** Bangladeshi Other ethnic origin Black African Other mixed origin ethnic Black British Other white ethnic Black Caribbean Pakistan Black, other White British Chinese White Irish C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngIndian White ScottishOther Asian | **Occupation:****Work contact no.:** **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].png** |

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| Are you on any regular medication, including anything you buy over the counter?**YES (list below) NO** Is there any family history of heart disease / diabetes / hypertension (please circle). If yes, give details below - N  |
| Have you had any operations/serious illnesses in the past ? | **YES NO** If yes, please give details with datesN |

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|  | **PREVIOUS MEDICAL HISTORY****Have there been any instances of :** N |
| **Condition** | **Please tick** | **Age Diagnosed** | **Date Diagnosed** |
| Asthma  |  |  |  |
| Cancer / Type |  |  |  |
| Diabetes  |  |  |  |
| Epilepsy  |  |  |  |
| Heart Disease  |  |  |  |
| High Blood Pressure  |  |  |  |
| Stroke  |  |  |  |
| Thyroid Disease |  |  |  |
| Do you have any Allergies YES NO If yes, what are they - |
|  |
| Do you have any drug related allergies YES NO If yes, what are they? |
| N |

**LIFESTYLE QUESTIONS**

**Please tick against the description that best matches your habits, in the tables A-F below**

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| **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngSMOKING – tick the answer which best applies** |
| Current smoker\* | Never smoked | Ex Smoker |
| *\*If you have ticked this box, we recommend you try to stop smoking. Did you know that you are more likely to quit if you see a smoking cessation adviser? Interested? Pick up a self referral from reception.* |

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| **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngEXERCISE – tick the answer which best applies** |
| Exercise Physically Impossible | Avoid Trivial Exercise | Enjoys Light Exercise |
| Enjoys Moderate Exercise | Enjoys Heavy Exercise | Competitive Athlete |

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| **ALCOHOL –** *GUIDE TO ALCOHOL UNITS* * *Single shot gin/vodka/whisky=1 unit ● Pint beer/cider/lager=2 units*
* *Standard glass of wine=2 units ● Large glass of wine=3 units*

**MEN – How often do you have 8 or more units on one occasion – add up the number of units then tick answer below****WOMEN – How often do you have 6 or more units on one occasion – add up the number of units then tick answer below****C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].png** |
| 0. Never | 1. Less than monthly | 2. Monthly | 3. Weekly | 4. Daily or almost daily |

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| **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngHow often during the last year have you been unable to remember what happened the night before because you had been drinking?** |
| 0. Never | 1. Less than monthly | 2. Monthly | 3. Weekly | 4. Daily or almost daily |

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| **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngHow often during the last year have you failed to do what was normally expected of you because of drinking?** |
| 0. Never | 1. Less than monthly | 2. Monthly | 3. Weekly | 4. Daily or almost daily |

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| **C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngIn the last year, has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?** |
| 0. No | 2. Yes, on one occasion | 4. Yes, on more than one occasion |

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| **Do you need sign language support?**Y / N**Do you need an interpreter?**Y / NIf yes, please state what language you speak \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].png |

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| **For female patients only**  | Please state previous Cervical Smear date: N |
| Contraception method used : | Pill | Coil | Implant | Injection | Sterilised |

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| *Was Proof of Identity shown?**Please state:*  |  *Y / N*  |
| *Was Proof of Address shown?**Please state:*  |  *Y / N* |
| *Was a Urine sample taken?* |  *Y / N* | *Reception Initials : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**C:\Users\vicky\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\SKRWTIF3\80px-LetterR.svg[1].pngDate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *NPHC appt made?* |  *Y / N* |

***For office use only:***