HEATH LANE SURGERY

FOR OFFICE USE ONLY
Photo ID ☐ Address ID ☐
Reception ☐ Nurses ☐
Admin ☐

New Patient Health Questionnaire

First Name: _____ Surname: _____
DOB: _____ Age:_____ Male/Female: _____
Address: _____
_____Postcode: _____
Telephone Numbers: Home: _____
Mobile: _____ Work Number: _____
Email Address: _____
Occupation: _____

Are you or have you been a serving member of the: Army ☐ Royal Navy ☐ Royal Marines ☐ Royal Air Force ☐ If yes, which? & include ranking number_____ Are you the family associate of a past or present serving member of the armed forces? Yes ☐ No ☐
Discharge from services date_____
Do you have any communication needs due to disability impairment or sensory loss to help us to make sure that you receive communication in a format that you can understand?

Yes ☐ No ☐ If Yes, please provide further details

ALL ABOUT YOU:

Ethnic Group: (Please Tick ✓)

☐ White British
☐ White Irish
☐ Any Other White Background
☐ Mixed White & Black Caribbean
☐ Mixed White & Black African
☐ Mixed White & Asian
☐ Any other Mixed Background
☐ Chinese
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any Other Asian background
☐ Black Caribbean
☐ Black African
☐ Any other Black Background
☐ Any Other ethnic Group

Language

Main spoken language: _____

Do you require an interpreter? Yes ☐ No ☐

Height: _____ Weight: _____ Waist Measurement: _____
Blood Pressure: 1st Reading _____/_____ 2nd Reading _____/_____

Allergies/ Allergies to Medication: Yes ☐ No ☐ (If yes please specify)
_____

Current Medications: Yes ☐ No ☐ (If yes please specify) _____
_____
_____
Nominated Pharmacy (EPS) _____
(Where would you like your prescription sent to)

Lifestyle

Exercise: (Please Tick ✓) Light ☐ Moderate ☐ Heavy ☐ Unable ☐
Diet: (Please Tick ✓) Vegetarian ☐ Vegan ☐ Normal ☐ Diabetic ☐

Please tell us about your smoking habits: Do you smoke? Yes ☐ No ☐

If Yes, what do you primarily smoke: Cigarettes / Cigar / Pipe **(please circle)**

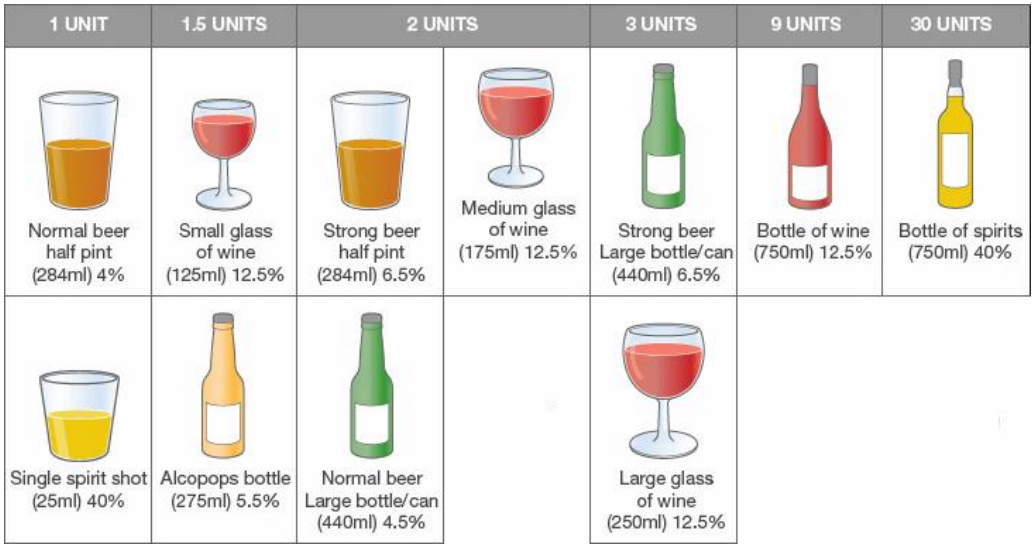
How many do you smoke a day? _____

Would you like advice on quitting? Yes ☐ No ☐

Are You an Ex-Smoker? Yes ☐ No ☐ When did you quit? _____

How many did you used to smoke a day? _____

Please tell us about your alcohol consumption:



Alcohol History: Number of units per week? _____ Teetotal ☐

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	

Next of kin: Name: _____ Relationship to you:_____

Next of kin address: _____

_____

Telephone number: _____

Do you have a carer? Yes ☐ No ☐ Their contact details: _____

Do you consent for your carer to be informed about your medical care? Yes ☐ No ☐

Are you a carer? Yes ☐ No ☐ If Yes, for whom? _____

If applicable

Date of last smear _____ Result _____

Date of last mammogram _____ Result _____

Do you use any form of contraception? Yes ☐ No ☐ (if yes, please specify)

_____

Any previous illnesses, Operations or medical impairments

_____

_____

_____

Have you ever had any of the following conditions?

	✓			✓	
Epilepsy		Year	DVT		Year
High Blood Pressure		Year	Mental Illness (inc Depression)		Year
Heart Attack		Year	Diabetes (Type 1 or Type 2)		Year
Angina (stable/unstable)		Year	Asthma		Year
Stroke		Year	COPD		Year
Transient Ischaemic Attack		Year	Osteoporosis		Year
Cancer		Year	Peripheral Vascular Disease		Year
Rheumatoid Arthritis		Year	Thyroid Disorder		Year

Do you have family history of any of the following?

	✓			✓	
High Blood Pressure		Who	DVT / Pulmonary Embolism		Who
Ischaemic Heart Disease Diagnosed aged >60yrs		Who	Breast Cancer		Who
Ischaemic Heart Disease Diagnosed aged <60yrs		Who	Any Cancer Specify type:		Who
Raised Cholesterol		Who	Thyroid Disorder		Who
Stroke		Who	Diabetes		Who
Asthma		Who	COPD		Who
Osteoporosis		Who	Mental Health Disorder		Who
Epilepsy		Who	Kidney Disease		Who

Please record any additional information about you that you think is important for us to know?

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

More information can be found by visiting: www.nhscarerecords.nhs.uk

Tick this box ☐
If you wish to opt out of the SCR

Enhanced Data Sharing Module (eDSM)

Whilst the SCR mentioned shares a very small portion of your medical record across the whole NHS, the eDSM shares a much fuller view of your records but with local NHS providers – and only when you give explicit consent at the point of care.

Tick this box ☐
If you wish to opt out of the eDSM

Thank you for completing this form. If you would like a health check with the nurse please make an appointment at Reception.

Date form completed _____