



## Highfield Surgery New Patient Health Questionnaire

Title: Mr Mrs Miss Ms	Surname
Date of birth / /	First names
Occupation/School/College <small>If school please state which school</small>	Previous surnames

Home Address	Home Tel
	Work Tel
	Mobile
Postcode	Email

Mothers surname <small>(if new patient is a child)</small>	Name of school <small>(If child is in full time education)</small>
Next of Kin	Relationship
Contact number of next of kin	

### Personal Medical History

Do you suffer from the following:	
Heart disease	Yes/No
Hypertension	Yes/No
Diabetes	Yes/No
Asthma	Yes/No
COPD	Yes/No
Are you allergic to anything:	
Please list any serious illnesses/operations/accidents/disabilities (and for any pregnancy related problems) and the year they took place:	

### Medication

Please list any medication that you are currently taking:

### Lifestyle

Do you smoke?	Yes/No
How many cigarettes/oz of tobacco a day?	
Have you ever smoked?	Yes/No
When did you give up?	
Would you like any advice on giving up?	Yes/No

Do you drink alcohol	Yes/No
Average amount per week	
Pints of beer Qty	Glasses of wine Qty
Pints of cider Qty	Measures of spirit Qty
Bottles of Alcohol pops Qty	

Please circle the appropriate response:

Questions	0	1	2	3	4	Your score (office use only)
How often do you have a drink that contains alcohol	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you drinking	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

### Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease:	Please state: Relationship and Age
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### Women

Have you ever had a cervical smear?	Yes/No
If 'yes' please state when and where	

### Carers Information

Are you a carer?	Yes/No
Do you have a carer?	Yes/No
If 'yes' please state there name and address and relationship	

### Ethnic Group – please circle which one applies to you

White: British	Irish	Other please state
Black: Caribbean	African	Other please state
Asian: Indian	Pakistani	Chinese
Other please state		
Mixed: White + black Caribbean	White + Black African	
White + Asian	Other please state	

**Thank you for completing the form and welcome to Highfield Surgery**