

NEW PATIENT HEALTH QUESTIONNAIRE FOR ADULTS

PATIENT DETAILS

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname	
Date of Birth		First names	
Home Address: Postcode:		Previous Surnames	
		Occupation	
		Home Tel	
		Mobile	
		Work Tel	
		Email	

OTHER FAMILY MEMBERS REGISTERED WITH MINDEN FAMILY PRACTICES

Name	Date of birth	Address

Country of origin:	
What is your first language?	

Name and address of your previous GP

ETHNIC GROUP

White	<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other (please specify)
Black	<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other (please specify)
Asian	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify)
Mixed	<input type="checkbox"/> White + Black Caribbean <input type="checkbox"/> White + Black African
	<input type="checkbox"/> White + Asian <input type="checkbox"/> Other (please specify)

PROOF OF IDENTITY AND ADDRESS PROVIDED?

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Driving License	<input type="checkbox"/> Passport	<input type="checkbox"/> Utility Bill
<input type="checkbox"/> Allowance Book	<input type="checkbox"/> Solicitor's Letter	<input type="checkbox"/> Offer of Tenancy	<input type="checkbox"/> Other

MEDICAL INFORMATION

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

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Have you ever suffered from? (tick as appropriate)

Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Blindness / Glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Attack / Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Depression	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Eczema / Hayfever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	COPD	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Please list any medicines being taken and the amount:

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Are you registered disabled? (If yes, please give details)

Yes No

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Are you allergic to any medicines and if so, which?

Yes No

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Have you ever refused treatment/screening of any kind and if so, what?

Yes No

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OTHER INFORMATION

Carers			
Do you have a carer? (If yes please give details)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a carer? (If yes please give details)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will			
Do you hold a Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)</i>			
Women			
Have you ever had a cervical smear?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'YES', please state WHEN and WHERE			
Smoking			
Do you smoke?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'No', have you ever smoked?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?			
Would you like advice on giving up smoking?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol			
1 drink (unit) = 1/2 pint of beer or 1 glass of wine or 1 single spirits			
Do you drink ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you do drink how many units do you drink per week?		Units	
Height and Weight			
What is your height?		What is your weight?	

FAMILY HISTORY

<p>Please state any serious illness, in particular heart disease, strokes, high blood pressure diabetes or any inherited disease</p>

FOR PATIENTS AGED 65 AND OVER

<p>Please give name, address and telephone number of next of kin</p>

FOR PATIENTS AGED 65 AND OVER OR THOSE WITH A CHRONIC DISEASE (EG ASTHMA OR DIABETES)

<p>Have you had a flu vaccination? Enter date or 'never':</p>	
<p>Have you had a pneumococcal vaccination? Enter date or 'never'</p>	

<p>Signature</p>	<p>Date</p>

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you.