**NEW PATIENT QUESTIONNAIRE**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 Scottish  Other 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 dates    N |

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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 |

|  |
| --- |
| **Do you need sign language support?**  Y / N    **Do you need an interpreter?**  Y / N    If 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:***