Dr Lister & Partners

New Patient Health Questionnaire for Adults

Your Contact Details

Title (Mr,Mrs,Miss,Ms,Other		Surname	
Date of Birth		First Name	
Occupation		Previous Surnames	
Home Address (inc. flat number if appropriate)		Home Tel	
		Work Tel	
		Mobile	
		Email	
Postcode			

Contacting You

I agree that I may be contacted from time to time, via email and/or SMS (text), with practice news, advice about my health and/or appointments.

Yes	No

Information About You

What is your height?

What is your weight?

What is your first language?

Do you need an interpreter?

Yes	No

Ethnic Group

White	□ British	□ Irish	□ Other (please specify)	
Black	□ Caribbean	□ African	□ Other (please specify)	
Asian	□ Indian	□ Pakistani □ Chinese	□ Other (please specify)	
Mixed	□ White + Black Caribbean □ White + Black African □ White + Asian		□ Other (please specify)	

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Previous GP

Name and Address of Previous GP

Proof of Identity and Address Provided

□ Birth Certificate □ Driving Licence □ Passport □ Utility Bill
□ Allowance Book □ Solicitor's letter □ Offer of Tenancy □ Other (please specify)

Medical Information

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

Have you ever suffered from? (circle as appropriate)

Epilepsy	Yes	No	Blind/Glaucoma	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Heart Attack/Stoke	Yes	No	Depression	Yes	No
Cancer	Yes	No	Asthma	Yes	No
Eczema/Hay Fever	Yes	No	COPD	Yes	No

If yes, please state the year(s) when were you first diagnosed?

Please list any medicines being taken and the amount:

Are you registered disabled? (if yes, please give details) Yes No

Are you allergic to any medicines and if so, which? Yes No

Have you ever refused treatment of any kind and if so, what and when? Yes No

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Medical Information continued

Have you ever suffered from? (circle as appropriate)

Anxiety Yes No

Depression Yes No

OCD Yes No

Bipolar Disorder Yes No

If yes to any of these, please state the year(s) when you were first diagnosed?

Do you have any other medical health issues? (If yes please give details) Yes No

Are you receiving or have you received any treatment or therapy? (If yes please give details of your care and when you received it) Yes No

Carers

Do you have a carer? (If yes please give details) Yes No

Are you a carer? (If yes please give details) Yes No

Will

Do you hold a Living Will? Yes No

(*A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)*

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Medical Information continued

Women

Have you ever had a cervical smear? (If yes please state when, where and the result)

Yes	No

Smoking

Do you smoke?

Yes	No

If No, have you ever smoked?

Yes	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?

Yes	No

Alcohol

(1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits)

Men: How often do you have EIGHT or more drinks on one occasion? Please circle

Never	Less than a month	Monthly	Weekly	Daily

Women: How often do you have SIX or more drinks on one occasion? Please circle

Never	Less than a month	Monthly	Weekly	Daily

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never	Less than a month	Monthly	Weekly	Daily

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

Yes	No

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Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

Next of Kin

Please give the name, address, telephone number and relationship of next of kin.

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter the date or never

Have you had a pneumococcal vaccination? Enter the date or never

Signature: _____ Date:_____

Signature on behalf of Patient: _____