New Patient Health Questionnaire

Please complete all sections

YOUR CONTACT DETAILS

Title Mr Mrs Miss Ms Other

Surname:

Date of Birth:

First Names:

Occupation:

Previous Surnames:

Home Address:

Home number:

Postcode:

Mobile number:

Email address:

INFORMATION ABOUT YOU

What is your height?

What is your weight?

What is your first language?

ETHNIC GROUP

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:

PREVIOUS OR CURRENT GP

Name and Address :

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? (CROSS OUT AS APPROPRIATE)

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

PLEASE LIST ANY MEDICINES BEING TAKEN AND THE AMOUNT

(if known):

ARE YOU REGISTERED DISABLED?

(If yes, please give details) Yes / No

DO YOU HAVE ANY ALLERGIES? Please list if Yes.

Yes / No

HAVE YOU EVER REFUSED TREATMENT/SCREENING OF ANY KIND AND IF SO, WHAT?

Yes / No

HAVE YOU EVER SUFFERED FROM? (tick as appropriate)

Anxiety	Yes / No	Depression Yes / No
OCD	Yes / No	Bipolar Disorder Yes / No

DO YOU HAVE ANY OTHER MENTAL HEALTH ISSUES? (If yes please give details)

ARE YOU RECEIVING OR HAVE YOU RECEIVED ANY TREATMENT OR THERAPY FOR THE ABOVE? (If yes please give details)

CARERS

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

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

WOMEN

Have you ever had a cervical smear? Yes / No
(Please state the last date)

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 = 1/2 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?
WOMEN: How often do you have SIX or more drinks on one occasion?

Never | **Less than Monthly** | **Monthly** | **Weekly** | **Daily**

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 name, address and telephone number of next of kin. Please also state the contact details of your power of attorney if you have one.

FOR PATIENTS AGED 65 AND OVER OR THOSE WITH A CHRONIC DISEASE (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or 'never':

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