NB Would you please provide a urine sample in the bottle provided (white topped) and bring it to your appointment. If you don't require an appointment it can be left at reception.

New Patient Health Questionnaire

To register with the Practice please complete the following questionnaire as fully as possible. This will help the Doctor to make an initial assessment of your health that will help in your future treatment. (Please complete this form in **BLOCK CAPITALS**.)

Surname ..... Forenames .....

Address .....

..... Postcode .....

Date of Birth ..... /..... /..... Marital Status .....

Home Tel: Area Code: ..... Mobile Tel: .....
Phone No: .....

Would you like the surgery to contact you?
(By ticking the box you consent to the practice contacting you via the methods stated below.)
E-mail ☐ Text ☐
Email Address: .....

Signature: ..... (Signature must be present.)

Ethnicity ..... Occupation .....

Language .....

For Children Only:

Name of Parent or Guardian ..... Relationship .....

Name and Address of School .....

..... Tel No: .....

Next of Kin

Surname ..... Forename(s) .....

Relationship ..... Tel No: .....

If you have a repeat slip from your previous Doctors' Surgery please bring this along so that the Medications can be transferred to your Medical Record here.

FAMILY HISTORY

(If there is a history of any of the following illnesses in your family which go back **ONE GENERATION** i.e. Parents, Siblings, Grandparents, Aunts and Uncles. Please record these on the page below.)

Breast Cancer	……	Relationship	……	Age Diagnosed	……
Ovarian Cancer	……	Relationship	……	Age Diagnosed	……
Bowel Cancer	……	Relationship	……	Age Diagnosed	……
Diabetes	……	Relationship	……	Age Diagnosed	……
		Relationship	……	Age Diagnosed	……
Heart Disease	……	Relationship	……	Age Diagnosed	……
(i.e. Heart Attacks, Angina)		Relationship	……	Age Diagnosed	……
High Blood Pressure	……	Relationship	……	Age Diagnosed	……
Stroke	……	Relationship	……	Age Diagnosed	……
High Cholesterol	……	Relationship	……	Age Diagnosed	……
Other Cancer	……	Relationship	……	Age Diagnosed	……

Allergies – Please give details of any known allergies.

……

Medication – Please give details of any medication that you are taking prescribed or over the counter medicines:

PAST MEDICAL HISTORY (including Treatment and Operations)

Female Patients Only:

Date of most recent Cervical Smear ..... /..... /.....

Result of most recent Cervical Smear .....

CARERS

Are you a carer for a sick or frail relative? Yes ☐ No ☐

If '**Yes**' please give the Name and Date of Birth of this relative:

Surname: ..... Forename(s): .....

Date of Birth: ..... /..... /.....

SMOKING

(Please tick the boxes and fill in the appropriate sections that apply to you.)

Do you Smoke? Yes ☐ No ☐

If '**Yes**', how many Cigarettes per day? .....
Cigars per day? .....
Ounces of Tobacco per day? .....

Are you an Ex-Smoker? Yes ☐ No ☐

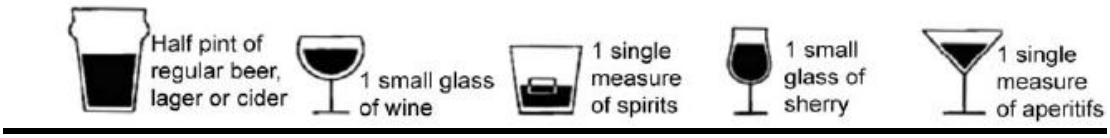
If '**Yes**', how many Cigarettes per day? .....
Cigars per day? .....
Ounces of Tobacco per day? .....

Never Smoked Tobacco? ☐

Please continue to the next page ->

ALCOHOL CONSUMPTION

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Provided by www.alcohollearningcentre.org.uk

Is there anything else you would like us to know? ……

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