New Patient Health Questionnaire for Adults

Your Contact Details

Title	Date of Birth
Surname	
First Names	
Previous Surnames	
Home Address (inc. flat number if appropriate)	
Postcode	Occupation
Home Tel	Work Tel
*Mobile	Email

Information About You

What is your height?		
What is your weight?		
What is your first language?		
Do you need an interpreter?	Yes	No
Have you ever been a member of the armed forces?	Yes	No

Previous GP

Name and address of previous GP

Ethnic Group (please tick)

White

British	Irish	Other

Black

Caribbean	African	Other

Asian

Indian	Pakistani	Chinese	Other

Mixed

White and Black Caribbean	White and Black African	White and Asian	Other

Medical Information

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

Have you ever suffered from? (tick as appropriate)

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

Please list any medicines being taken and amount:

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

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

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

Have you ever suffered from? (tick 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 mental health issues? (If yes please give details)

Are you receiving or have you received any treatment or therapy? (If yes, please give details of your care and when you received it)

Carers

Do you have a carer? (If yes, please give details)

Are you a carer? (If yes, please give details including who you care for)

Do you live alone?

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

Women

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

Smoking

Do you smoke?	Yes	No
If 'No', have you ever smoked?	Yes	No
If you 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

How often do you have a drink containing alcohol? (Please tick)

Never	
Monthly or less	
2/4 times a month	
2/3 times a week	
4+ times a week	

How many units of alcohol do you drink on a typical day you are drinking? (Please tick)

1-2 units	
3-4 units	
5-6 units	
7-9 units	
10+ units	

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? (Please tick)

Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost 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, 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? (If yes, enter date)	Yes	No
A pneumococcal vaccination? (If yes, enter date)	Yes	No

Contacting You

I agree that I may be contacted from time to time, via email and/or text message, with practice news, advice about my heath and/or appointment reminders.

Yes	No

Signature **Date**

Staff use only. If aged 75 or over, please inform the patient of their accountable named GP.