# NEW PATIENT HEALTH QUESTIONNAIRE

## Your Contact Details

**Title:** Mr / Mrs / Miss / Ms

**Surname:_____**

**First Name:_____**

**Previous Surname:_____**

**D.O.B: _____**

**Occupation: _____**

**Are you a Military Veteran?** *Yes/No*

**Home Address:**

Post Code:

**We use text (SMS messaging) and email to send reminders of appointments and to contact you about results if needed. By giving your mobile number and email address you are giving us consent to use them for health purposes.**

**Home:_____**

**Mobile:_____**

**Email:_____**

**Information About You**

**What is your height? _____**

**What is your weight? _____**

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

**Are you a carer?** *(If yes, please give details)* ***Yes/No***
**This does not apply to you if you do it as a profession, only if you care for a relative or friend.**

**Preferred method of contact – for most of us or preferred method of contact is our home number or mobile number but for example, if you suffer from hard of hearing or blindness this may not be suitable for you. If you or someone you are caring for wishes us to contact you in another way, please do let us know by informing either reception of the practice manage. We will then record your need by highlighting this on your medical record so others are aware.**

**Please indicate below if you have any difficulties -**

**Hearing difficulty**

**Sight impairment**

**Learning difficulty**

**Other**

**What is your first language? _____**

**Ethnic Group:** *(Circle appropriate)*

| | | | | |
|---|---|---|---|---|
| **White** | British | Irish | Other | |
| **Black** | Caribbean | African | Other | |
| **Asian** | Indian | Pakistani | Chinese | Other |
| **Mixed** | (*Please State)* | | | |

**Previous GP**

**Name and Address of Previous GP:**

| |
|---|
| |

**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 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 provide your repeat medication list (or list any medicines being taken and the amount if this is not available).**

| Medication & dose | Date | Medication & dose | Date |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**Are you registered disabled?** *Yes/no*

**Do you have a learning disability (If yes, please give details)** *Yes/No*

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

| Medication & dose | Date | Medication & dose | 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?**

_____
_____
_____

**Are you interested in giving up smoking? Yes/No**

**Alcohol** *1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit*

**Q1. How often do you alcohol:**

a. **never**
b. **monthly or less**
c. **2/3 times/month**
d. **2/3 times/week**
e. **4+ times/week**

**Q2. How many units of alcohol do you drink on a typical day, when you are drinking:**

a. **1/2 units**
b. **3/4 units**
c. **5/6 units**
d. **7/8 units**
e. **10+ units**

**Q3. 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?**

a. **never**
b. **less than monthly**
c. **monthly**
d. **weekly**
e. **daily or almost daily**

**To understand how we protect your data and what your data rights are, please read our privacy notice at www.belvideremedicalpractice.nhs.uk or ask at reception for a copy.**