**BEECHWOOD SURGERY**

New Patient Health Questionnaire

Name DoB Age

Ethnicity Marital Status Occupation

Main language (If not English, is English spoken YES/NO )

Height Weight BMI

**MEDICAL HISTORY**

Do you suffer from any conditions; eg: Asthma, Diabetes ,Heart Disease, Lung Disease, Cancer or other

**FAMILY HISTORY**

Do any of your family suffer from any of the above conditions? If so please give details and relationship

**Do you need a translator? If yes please specify the** language

**Do you have any allergies? YES/NO**

If yes please give details

**Have you had a MMR injection: YES / NO**

**Do you take regular medication? YES/NO**

Please give Details below:

|  |  |  |
| --- | --- | --- |
| Name of Medication | Daily dosage | How long have you been taking these medications? |
|  |  |  |
|  |  |  |
|  |  |  |

**Blood pressure checked in the last 5 years?** YES/NO

If you are aged 40+ please check your blood pressure in the waiting area and enter your reading

Here

Cholesterol check in last 5 years? YES/NO

**SMOKING**

Do you smoke? YES/NO If YES, how many cigarettes per day

If you smoke, how old were you when you started?

**EX SMOKERS**

If you used to smoke, when did you stop and how old were you when you stopped?

If you used to smoke, how many cigarettes did you smoke per day?

How did you quit? Willpower / Medications / Other

**ALCOHOL**

Do you drink alcohol? YES/NO If yes, how many units per day? …………..

How often have you had 6 or more units if a female, or 8 or more if male, on a single occasion in the last year?...................................... AUDIT C: (staff to complete) ………………………………..

**DIET**

Do you have a varied diet including milk, meat, vegetables and fruit? YES/NO

If not are you a vegetarian/vegan or other (please specify)

**EXERCISE**

For how many minutes/hours do you exercise at a time?

How many times per week?

What type of exercise do you do (walking, gym, gardening, dancing etc)

**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 | Monthlyor 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? | 0 - 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 |  |

**SCORE**

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

**FOR WOMEN**

Smear test; if aged between 25-65 when was your last test and where?

Are you using any contraceptive?

**CARERS**

Do you have anyone who looks after you or your daily needs as a Carer? YES/NO

If ‘YES’ would you like them to be aware of your health affairs here? YES/NO

If ‘YES’ please provide name and contact details

Do you act as an unpaid carer for a relative/friend? YES/NO

**DISABILITIES**

Do you have any disabilities? YES/NO, if yes please state below

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

If yes, do you give consent to share this information to other attached Health organisations such as hospitals, District Nurses etc. YES/NO

**CHILDREN UNDER 18 (or over if in full time education)**

Which school/college are you presently attending?

If not cared for by parents, give names of guardian?

**CHILDREN UNDER 5:** If youare registering a child who has been born or lived outside of the UK, please provide full details all the immunisations your child has received

**SUMMARY CARE RECORD** This will be created as part of your registration and can be used in emergency care anywhere in England with your permission. If you require further information please ask at Reception.

**PATIENT CONTRACT**  Please be aware that you may be asked for a brief description of your reason for booking an appointment; this is not meant to be intrusive, but to ensure that your request is dealt with as quickly and efficiently as possible, and that you are booked with the right clinician (doctor, nurse practitioner, or nurse).

We request that you agree to the following:

* Attend all booked appointments and arrive on time. If you are unable to attend please cancel at least 2 hours before the appointment time. This is so that we can accommodate other patients who need to be seen by clinicians. **Repeated non-attendance could result in removal from the practice register.**
* Inform the surgery of any change in personal details ie: name, address, telephone number as we may need to get in touch with you urgently.
* Be polite at all times; we have a Zero Tolerance Policy with regard to any form of aggressive or abusive language or behaviour towards any doctors or staff at this practice.
* Please do not get annoyed with the receptionist if your appointment time is delayed. Although we endeavour to run clinics on time, the individual clinical needs of each patient can sometimes cause a delay which is beyond our control.

**Patient Signature** **Date**

**Please print name**

Thank you for completing this questionnaire.

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SURGERY USE ONLY

**Appointment with**

Doctor -

Nurse/HCA -

No appointment needed -