

# ALBANY SURGERY

New Patient Health Questionnaire Under 16 years of age

[www.albanysurgery.co.uk](http://www.albanysurgery.co.uk)

Title: Mr / Mrs / Ms / Miss / Other \_\_\_\_\_  
First Name: \_\_\_\_\_  
Surname: \_\_\_\_\_  
Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_  
Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Town & Country of Birth: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_  
Home Number: \_\_\_\_\_  
Mobile: \_\_\_\_\_  
Email: \_\_\_\_\_

Emergency contact/Next of Kin:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Relationship to you: \_\_\_\_\_  
Phone number: \_\_\_\_\_

Would you be happy for us to use your mobile number and/or email address to inform you via text messaging of things such as appointment reminders, dates for flu clinics, health checks due etc?

Email? Yes / No      Text/SMS? Yes / No

## Ethnic Group:

White:  British    Irish    Other: \_\_\_\_\_  
Black:  Caribbean    African    Other: \_\_\_\_\_  
Asian:  Indian    Bangladeshi    Pakistani    Chinese  
       Other: \_\_\_\_\_  
Mixed:  White + Black Caribbean    White + Black African  
       White + Asian    Other: \_\_\_\_\_

First Language: \_\_\_\_\_      Do you need a translator?      Yes / No

Designated Chemist (where you would like your prescriptions sent) \_\_\_\_\_

## Do you have a Carer?

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

If yes then please give details of your carer:

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Post Code: \_\_\_\_\_

Home Number: \_\_\_\_\_

## Are YOU a Carer?

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

If yes -who are you a carer for?

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Post Code: \_\_\_\_\_

Home Number: \_\_\_\_\_

Mobile: \_\_\_\_\_

# Personal past medical history

Patient Name: \_\_\_\_\_

**Please list any other serious illnesses / operations / accidents / pregnancy-related issues and the year they took place:**

Health Event	Year

## Family history of illness:

Condition.	Family member	Age at onset
Diabetes		
Osteoporosis		
Heart attack		
Stroke /TIA		
Asthma		
Other hereditary disease. (please specify.)		
Cancer ( please specify type)		

### Are you on any regular medication?

Please note that you will need to book a telephone consultation with your new GP before we can issue any repeat medications.

It would help if you have the repeat medication slip from one of your old prescriptions.

Medication	Dose	How many times daily?
1		
2		
4		
5		
6		

### CHILDREN ONLY !

#### Immunisations:-

(please tick and provide dates if known)

#### Baby Immunisations:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

#### 12 month Immunisations:

\_\_\_\_\_

#### Pre-School Boosters:

\_\_\_\_\_

Which school does your child attend?

\_\_\_\_\_

#### Do you have any severe allergies:

No / Yes - give details below

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

#### Are you under the care of a hospital consultant for a medical condition?

Or have a Social Worker?

Name of professional if known.	Condition you see the professional for.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

We create Summary Care Records for all our registered patients. This is a summary of your basic medical information that is accessed in the event of you needing urgent or emergency treatment (eg. A&E). If you wish to opt out of this service, please ask at Reception for an Opt-Out form.

This is one unit of alcohol...



Half pint of regular beer, lager or cider



1 small glass of wine



1 single measure of spirits



1 small glass of sherry



1 single measure of aperitifs

ALCOHOL	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/almost daily	

## SMOKING

Do you smoke? Yes / No

If 'Yes', how many cigarettes/ounces of tobacco per day? \_\_\_\_\_



If you are an ex smoker, when did you quit?  
\_\_\_\_\_

Would you like help and advice on how to quit?

Yes / No