ALBANY SURGERY

New Patient Health Questionnaire

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: __ __ __ __ __ __ __ __ __ __ __
Work Number: _____
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

Medical history Do you have a history of…(please tick)	If yes, when was this diagnosed?
Heart attack	
Stroke/TIA	
cancer	
eczema	
Asthma	
COPD	
Diabetes	
Kidney disease	
High blood pressure	

Mental Health Issues: Do you have a history of…..(please tick)	If yes, when was it diagnosed?
anxiety	
depression	
OCD	
Bipolar disorder	
Personality disorder	
Psychotic Disorder	
Other mental health issue(please specify)	

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)		

CHILDREN ONLY !

Immunisations:-
(please tick and provide dates if known)

Baby Immunisations:
- o **1** _____
- o **2** _____
- o **3** _____

12 month Immunisations:
_____

Pre-School Boosters:
_____

Which school does your child attend?
_____

WOMEN ONLY!

Have you had a hysterectomy? Yes/No
Total/Subtotal
Date of last smear (if known):
_____
Was it normal? Yes /No

Current method of contraception if used.

Do you have any severe allergies:
No / Yes - give details below
1_____
2_____
3_____

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		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

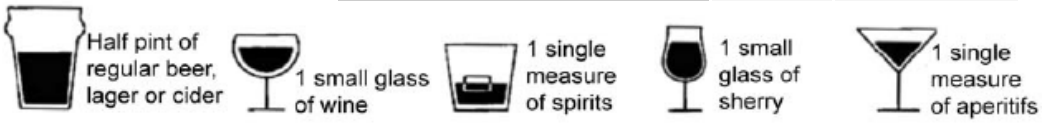
Are you under the care of a hospital consultant for a medical condition?

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

If known please tell us your :

Height:_____ Weight: _____
BP ____/____

This is one unit of alcohol...



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

Have you ever had a pneumonia (pneumococcal) vaccination ?
Yes / No
If Yes, approx date: ___/___/_____

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.