

PERSONAL DETAILS AND HEALTH QUESTIONNAIRE FOR NEWLY REGISTERED PATIENTS

SURNAME:

SEX: M/F DATE OF BIRTH:

FORNAME(S):

TITLE:

MARITAL STATUS:

**ADDRESS:
(incl postcode)**

**TELEPHONE NO: Home:
Work:
Mobile:**

NEXT OF KIN:

**PREVIOUS DOCTOR
(And previous surgery address)**

ETHNICITY: (Please circle)

British/Mixed British
Irish
Other White
White and Black Caribbean
White and Black African
White and Asian
Other Mixed
Indian British
Pakistani/British Pakistani
Bangladeshi/British Bangladeshi
Other Asian
Caribbean
African
Other Black
Chinese
Other

FIRST LANGUAGE SPOKEN

English YES/NO
If No Please give details for first language

HEIGHT ftinches

WEIGHT stlbs orkg

Do You Smoke? Yes No

If yes, since when

How many per day?

If you have smoked and given up when did you stop?

Would you like to stop smoking?

Would you like to see a smoking cessation advisor?

How often do you have a drink that contains alcohol (Please Circle)

Never / Monthly or less / 2 – 4 times per month / 2-3 times per week / 4+times per week

How many standard alcohol drinks do you have on a typical day when you are drinking (Please Circle)

1 to 2 3 to 4 5 to 6 7 to 8 10+

How often do you have 6 or more standard drinks on one occasion (Please Circle)

Never / Less than monthly / Monthly / Weekly / Daily or almost daily

1. Are you a Carer? YES/NO

If Yes, please give details:

2. Please list any serious illness, accidents, operations with year of occurrence:

<u>Year</u>	<u>Condition</u>	<u>Treatment/Operation</u>
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3. Are you currently under the care of a hospital specialist? YES/NO If yes, please specify:

4. Are you currently on a hospital waiting list? YES/NO If yes, please give details as follows:

Hospital.....	Consultant
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Treatment.....	Date on waiting list
	(please give approximate date if you do not have one)

5. Do you currently, or have you ever suffered from any of the following?

a) Asthma	YES/NO	g) Epilepsy	YES/NO
b) Blindness/Glaucoma	YES/NO	h) Hay Fever	YES/NO
c) Bowel problems	YES/NO	i) Heart Attack/Disease	YES/NO
d) Cancer	YES/NO	j) High Blood Pressure	YES/NO
e) Depression	YES/NO	k) Stroke	YES/NO
f) Diabetes	YES/NO	i) Ulcers or chronic indigestion	YES/NO

6. Are you allergic to anything? YES/NO If Yes, please specify:

7. Are you taking any drugs or medicines prescribed by a doctor? YES/NO If Yes, please give details:

<u>Name of Medicine/Tablets</u>	<u>Dose or Strength</u>	<u>How many times a day?</u>
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a)
b)
c)

or *please attach a repeat medication slip from your previous Doctor*

YOU WILL NEED TO SEE YOUR NEW GP BEFORE ANY MEDICATIONS ARE ISSUED

8. Are you currently taking any medicine not prescribed by a Doctor? YES/NO

If Yes, please specify:

9. Is there any history of the following diseases in your family? (i.e. parents, brothers, sisters)

YES/NO	If yes, please give details below:		
<u>Disease</u>	<u>Relation</u>	<u>Disease</u>	<u>Relation</u>
a) Diabetes		d) Asthma	
b) Heart disease		e) Stroke	
c) High blood pressure			

10. Do you have any major handicap or disability YES/NO If yes, please give details:

11. Do you undertake regular sport or exercise? YES/NO
If yes please specify sport and frequency

12. How would you describe your diet: high fat, balanced, low fat, vegetarian or vegan

ADDITIONALLY FOR WOMEN ONLY:

13. How many pregnancies have you had?

14. Did you have any associated difficulties? YES/NO
(e.g. miscarriage, still-birth, difficult delivery, etc)

15. Are you taking any oral contraceptives? YES/NO
If yes, which brand and how long have you been taking it
Any previous brand? YES/NO If yes, please specify

16. If No, are you using any other birth control? YES/NO

17. Have you had a cervical smear test? YES/NO If yes, last date/year done

18. Have you had a breast screening test? YES/NO If yes, last date/year done

19. Have you had a hysterectomy? YES/NO If yes, please give date

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please complete in BLOCK CAPITALS and tick as appropriate

Mr Mrs Miss Ms
 Surname _____
 Date of birth _____
 First names _____
 Previous surname(s) _____
 NHS No. _____
 Town and country of birth _____
 Male Female
 Home address _____
 Telephone number _____
 Postcode _____

Please help us trace your previous medical records by providing the following information

Name of previous doctor while at that address _____

Address of previous doctor _____

If you are from abroad

Your first UK address where registered with a GP _____

Date you first came to live in UK _____

If you are returning from the Armed Forces

Address before enlisting _____

Enlistment date _____

Service or Personnel number _____

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances* **Not all doctors are authorised to dispense medicines*

I live more than 1 mile in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient Signature on behalf of patient _____ Date _____

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

Any of my organs and tissue or

Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature confirming my agreement to organ/tissue donation _____ Date _____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0845 60 60 400.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register _____ Date _____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is: (only if different from above, e.g. your place of work) _____

Postcode: _____

To be completed by the doctor

Doctors Name _____ HA Code _____

I have accepted this patient for general medical services

For the provision of contraceptive services

I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above _____ HA Code _____

I am on the HA CHS list and will provide Child Health Surveillance to this patient or

I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above _____ HA Code _____

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.

Distance in miles between my patient's home address and my main surgery is _____

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature _____

Name _____ Date _____

Practice Stamp _____