**NEW PATIENT HEALTH QUESTIONAIRE**

**Castlehead Medical Centre**

**Ambleside Road, Keswick CA12 4DB**

**Tel 017687 72025**

**PLEASE COMPLETE IN FULL**

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| **TITLE** |  |
| **FIRST NAMES** |  |
| **SURNAME** |  |
| **PREVIOUS SURNAME** |  |

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| **ADDRESS****POSTCODE** |  |

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| **TEL NO** |  |
| **WORK NO** |  |
| **MOBILE NO** |  |
| **E-MAIL** |  |
| **DO YOU AGREE TO TEXT MESSAGING SERVICE** | **YES NO** |

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| **DATE OF BIRTH****TOWN & COUNTRY OF BIRTH** |  |

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| **SEX** | **MALE FEMALE** |

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| **MARITAL STATUS** |  |

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| **OCCUPATION (IF RETIRED PLEASE STATE PREVIOUS OCCUPATION)** |  |

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| **ETHNIC GROUP – WOULD YOU DESCRIBE YOURSELF AS…..** | **WHITE BLACK ASIAN MIXED****BRITISH CARRIBEAN INDIAN WHITE+BLACK CARRIBEAN****IRISH AFRICAN PAKISTANI WHITE+BLACK AFRICIAN****CHINESE WHITE+ASIAN****OTHER PLEASE SPECIFY …………………………………………………………..** |
| **WHAT IS YOUR FIRST LANGUAGE****DO YOU REQUIRE AN INTERPRETER****DO YOU HAVE ANY COMMUNICATION NEEDS SUCH AS BRAILLE/LARGE PRINT/EMAIL**  | **YES NO****PLEASE SPECIFY** |

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| **NAME AND ADDRESS OF YOUR PREVIOUS GP** |  |

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| **HAVE YOU EVER LIVED OUTSIDE THE UK IN THE LAST 2 YEARS IF SO WHERE?** |  |
| **HAVE YOU EVER TRAVELLED OUTSIDE THE UK IN THE LAST 2 YEARS IF SO WHERE?** |  |

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| **PROOF OF IDENTITY** |  |  |  |
| **BIRTH CERTIFICATE** | **DRIVING LICENCE** | **PASSPORT** | **UTILITY BILL** |
| **ALLOWANCE BOOK** | **SOLICITORS LETTER** | **OFFER OF TENANCY** | **BANK STATEMENT** |
| **WAGE SLIP** | **OTHER** |  |  |

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| **ARE YOU HOUSEBOUND** | **YES NO**  |
| **DO YOU LIVE IN A CARE /NURSING /RESIDENTIAL HOME** | **CARE (13FX ) NURSING ( 13F61)****RESIDENTIAL (13FK)** |

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| **ARE YOU REGISTERED AS DISABLED**  | **YES NO**  |
| **DO YOU HAVE A CARER** | **YES NO PLEASE GIVE CONTACT DETAILS****NAME-****ADDRESS-****RELATIONSHIP-****TEL NO-** |
| **ARE YOU A CARER** | **YES NO** **IF YES PLEASE ASK RECEPTION FOR A CARERS FORM.** |
| **DOOR ACCESS KEY CODE - IF APPLICABLE** |  |
| **CONTACT IN CASE OF EMERGENCY/****NEXT OF KIN** | **NAME-****ADDRESS-****RELATIONSHIP-****TEL NO-** |
| **MEDICAL HISTORY** |  |
| **ANY KNOWN ALLERGIES****(PLEASE LIST)****ADVERSE REACTION TO DRUGS** **(PLEASE LIST)** |  |
| **CURRENT MEDICAL CONDITIONS (PLEASE LIST CONDITION (AND APPROX YEAR DIAGNOSED)****DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/** **MENTAL HEALTH PROBLEMS/ HEART DISEASE/****HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS** |  |
| **PLEASE LIST ANY CURRENT MEDICATION****NAME/STRENGTH/DOSE** |  |
| **FAMILY HISTORY – IS THERE ANY FAMILY HISTORY FOR THE FOLLOWING ILLNESSES-****DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/** **MENTAL HEALTH PROBLEMS/ HEART DISEASE/****HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS** |  |

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| **HAVE YOU EVER REFUSED TREATMENT/ SCREENING OF ANY KIND AND IF SO WHAT?** |  |

**LIFESTYLE**

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| **DO YOU DRINK ALCOHOL** | **YES NO** |
| **IF YES HOW MUCH DO YOU DRINK ALCOHOL AND HOW OFTEN****(SEE ATTACHED FORM FOR GUIDANCE)** | **NUMBER UNITS PER WEEK =** |

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| **SMOKING STATUS** | **NEVER SMOKED CURRENT SMOKER****EX-SMOKER**  |
| **CURRENT SMOKERS ONLY -WHAT DO YOU SMOKE (CIGARETTES/ PIPE/ ROLL YOUR OWN/ DRUGS/ CIGARS)****HOW MANY PER DAY****DO YOU WANT HELP TO STOP SMOKING** | **YES NO** |

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| **DO YOU EXERCISE?**  | **NONE LIGHT****MODERATE HEAVY** |
| **WHAT TYPE OF EXERCISE DO YOU DO?** |  |
| **HOW OFTEN DO YOU EXCERISE?** |  |

**WOMEN ONLY**

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| **DATE OF LAST CERVICAL SCREENING & RESULT (if known)** |  |
| **DATE OF LAST MAMMOGRAM & RESULT (IF APPROPRIATE)** |  |
| **MMR STATUS (MEASLES/MUMPS&RUBELLA) IF KNOWN** |  |
| **IF YOU HAVE ANY CHILDREN, IN WHAT YEARS WERE THEY BORN** |  |
| **DO YOU HAVE A CONTRACEPTIVE IMPLANT OR COIL FITTED** **PLEASE SPECIFY** | **DATE FITTED TYPE** |
| **DO YOU USE ANY OTHER FORM OF CONTRACEPTION****PLEASE SPECIFY** |  |

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| **DO YOU WANT TO REGISTER FOR PATIENT ONLINE ACCESS?****TO HAVE ONLINE ACCESS YOU MUST BE ABLE TO PROVIDE US WITH PROOF OF IDENTITY AND PROOF OF ADDRESS****APPLICATION FORM & TERMS AND CONDITIONS ARE ENCLOSED.** | **YES NO** |

**DO YOU HOLD THE FOLLOWING DOCUMENTATION – THE DOCUMENTS LISTED BELOW ARE REGARDING YOUR PERSONAL WISHES IN RESPECT TO ANY FUTURE MEDICAL TREATMENT, IF YES PLEASE BRING FORMS INTO THE PRACTICE SO THAT WE CAN RECORD THIS INFORMATION CORRECTLY ON YOUR MEDICAL RECORD.**

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| **DNA/CPR (DO NOT RESUSCITATE)** | **YES NO** |
| **ADVANCED DIRECTIVE** | **YES NO** |
| **POWER OF ATTORNEY WELFARE** | **YES NO** |
| **POWER OF ATTORNEY PROPERTY AND AFFAIRS** | **YES NO** |

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**All new patients who have repeat medications only need to make a 10 minute appointment to see the GP**

**All new patients over 16 years old and who are not on any repeat medication need a 20 minute appointment with the Health Care Assistant.**