PRINCE OF WALES GROUP PRACTICE

Confidential

New Patient Health Questionnaire

Personal details

Surname:

First name(s):

Gender: (please tick)

- Male
- Female

Date of birth:

Home Address:

Post Code:

Home telephone number:

Work telephone number:

Mobile telephone number:

Email:

If you have children please provide name, gender and date of birth for each child:

Name and address of previous GP:

Next of kin:

Relationship to you:

Phone number:

Have you registered with us before?

- **Yes**
- **No**

Occupation:

Are you

- **Retired**
- **Unemployed**
- **Long term sick**
- **Student**

Accomodation

- **Owner occupier**
- **Council rented**
- **Private rented**
- **Hostel**
- **Temporary**

What is your height?

What is your weight

Are you a Carer?

- Yes
- No

If yes, who are you a Carer for?

Do you have a Carer?

- Yes
- No

If yes, what is your Carer's name?

Are you housebound?

- **Yes**

- **No**

What is your country of birth?

Ethnic Group

Please tick below which best describes your ethnicity:

- White British
- White Irish
- Any other white background
- Pakistani or British Pakistani
- Bangladeshi or British Bangladeshi
- Indian or British Indian
- Any other Asian background
- Mixed White & Black Caribbean
- Mixed White & Black African
- Mixed White & Asian
- Any other mixed background
- Black or Black British, Caribbean
- Black or Black British, African
- Any other Black background
- Chinese
- Any other ethnic group

What is your main spoken language?

Do you need an interpreter?

- Yes
- No

Communication support needs

Do you have any information and communication support needs? For example, would you like information in **Large Print** or **Easy Read** format? Do you use a hearing aid or communicate in **British Sign Language**?

Please tell us your preferences:

NOTE: We have an email address dedicated for those with hearing impairment: princeofwalesgroup.hip@nhs.net

For children under 16:

Who looks after you?

- **Mother**
- **Father**
- **Both parents**
- **Carer**

Which school do you go to?

Medical history

Have you have a heart attack/angina?

- **Yes** **What year?**
- **No**

Have you had high blood pressure?

- **Yes**
- **No**

Have you had a stroke?

- **Yes**
- **No**

Have you had any psychiatric illness?

- **Yes**
- **No**

Have you ever suffered from any important medical illness, had a major operation or have been admitted to hospital?

- **Yes**
- **No**

If yes please give details of the condition, date and name of hospital you attended:

Are you allergic to any medication – like Penicillin or Aspirin?

- **Yes**
- **No**

If yes, please give details:

If you smoke or have ever smoked

If you smoke cigarettes, how many cigarettes do you smoke per day?

If you smoke a cigars, how many cigars do you smoke per day?

If you smoke a pipe how many ounces do you smoke a week?

Are you an ex-smoker?

- Yes
- No

If yes, when did you give up?

If you drink alcohol

How often do you have a drink that contains alcohol?

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

How many standard alcoholic drinks do you have on a typical day when you are drinking?

- 1-2
- 3-4
- 5-6
- 7-9
- 10+

How often do you have 6 or more standard drinks on one occasion?

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

How many units do you drink per week?

(*1 unit = half a pint of beer, small glass of wine, one shot spirit*)

Questions for women only

Do you use contraception?

- **Yes**
- **No**

What kind?

When was your last cervical smear test?

Where was it done?

Women over 50

Have you ever had an X-Ray for Breast Cancer?

- Yes
- No

Family history

Have any close relatives (*father*, *mother*, *sister*, *brother only*) ever suffered from any of the following: (please indicate who)

- **Heart attack**
    - Yes
    - No

Relative:

- **Stroke**
    - Yes
    - No

Relative:

- **Diabetes**
    - Yes
    - No

Relative:

- **High blood pressure**
    - Yes
    - No

Relative:

- **Asthma**
    - Yes
    - No

Relative:

- **Glaucoma**
    - Yes
    - No

Relative:

- **Cancer**
    - Yes
    - No

Relative:

SIGNATURE

I confirm that the information I have provided is true to the best of my knowledge.

Signed by patient:……

Date:

Signed on behalf of patient:……