PRINCE OF WALES GROUP PRACTICE

Confidential New Patient Health Questionnaire

To help offer you a high standard of care we ask all new patients to complete this questionnaire. It is important that you answer all questions as it may be several months before your medical notes arrive from your previous practice. This questionnaire is completely confidential and only used by staff to supplement your medical notes.

PERSONAL DETAILS

Surname:	**Children**	Gender M / F	Date of birth
Forenames:	Name:		
Date of birth: **Gender (M / F):**	Name:		
Phone: Home Work Mobile	Name:		
Home address:	Previous GP name / address:		
Email:	Have you registered with us before? Yes ☐ / No ☐		
Next of kin: Relationship to you: Phone number:	**Smoking** Do you currently smoke? Yes ☐ / No ☐ If Yes, how many per day and type? (cigg, pipe, etc.) If No, did you smoke in the past? Yes ☐ / No ☐ If Yes, how long ago?		
Type of accomodation: Owner occupier ☐ Council rented ☐ Private rented ☐ Hostel ☐ Temporary ☐	Occupation: Retired ☐ Unemployed ☐ Long term sick benefit ☐ Student ☐		
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 *one* box below which best describes your ethnicity:

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

What is the first or main language that you speak? ……. Need an interpreter? Yes ☐ / No ☐ …….....

Please indicate any communication support needs: Sign Language ☐ Large Print ☐ Other: ……..

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

Would you like to join our *Patient Participation Group* and help with our efforts to improve service? Yes ☐ / No ☐

If yes, please provide your email address: .....

HEALTH DETAILS

Medical History

Have you had a Heart Attack/Angina? Yes ☐ / No ☐

If Yes, what year?

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 had any other Illness, Accident, or Operation? Yes ☐ / No ☐

Condition / Operation	Date	Hospital

Alcohol

How often do you have a drink containing alcohol?

☐ Never	☐ Monthly or less	☐ 2 to 4 times monthly	☐ 2 to 3 times weekly	☐ 4 or more times weekly

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

☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10 or more

How often have you had 6 or more standard drinks on a single occasion in the last year?

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

How many units do you drink a week? ……...

(1 unit = ½ pint beer, spirit or small glass wine)

Allergies

Are you allergic to any medication – like Penicillin or Aspirin? Yes ☐ / No ☐

If Yes, please give details: ……..

……..

For Children Under 16

Who looks after you? (please tick)

Mother ☐ Father ☐ Both Parents ☐ Carer ☐

Which school do you go to? ……

For Women Only

Do you use contraception? Yes ☐ / No ☐

If Yes, what kind?

When was your last smear? ……..

Where was it done? ……

Previous GP ☐ Hospital ☐ Other ☐

For Women Over 50

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

Yes ☐ / No ☐

FAMILY HEALTH

Has anyone in your family had high blood pressure?

Yes ☐ / No ☐ If Yes, please indicate below:

Mother ☐ Father ☐ Sister ☐ Brother ☐

Has anyone in your family had a stroke?

Yes ☐ / No ☐ If Yes, please indicate below:

Mother ☐ Father ☐ Sister ☐ Brother ☐

Has anyone in your family had a heart attack or angina? Yes ☐ / No ☐ If Yes, please indicate below

Mother ☐ Father ☐ Sister ☐ Brother ☐

Have members of your family suffered from other health problems? Yes ☐ / No ☐ If Yes, please give details:

……..……

Was your relative over or under 60 when they had their first symptoms? Over 60 ☐ Under 60 ☐

SIGNATURE

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

Signed: …… Date: ……...

Signature of patient ☐ Signature on behalf of patient ☐