

New Milton Health Centre Practice
New Patient Health Questionnaire



Name _____

D.O. B. _____

Occupation _____

Telephone No. _____

This information will help us to care for you before your notes arrive from your previous doctor.

Have you ever had any of the following?

Angina, heart attacks or other heart trouble?

No

Yes

Strokes or mini-strokes (TIAs)

High Blood Pressure

Diabetes

Asthma Chronic Bronchitis or Emphysema

Cancer of any type

Epilepsy, fits or seizures

Thyroid Problems

Kidney Disease

Significant Mental Health problems or severe Depression

Have you had or been treated for TB?

Any other serious illnesses? Please list below.

.....
Please list any regularly prescribed medication you take

.....

.....

Do you have a family history of cancers, diabetes, heart disease, glaucoma or stroke? If yes, please list below

.....

TB is prevalent in certain countries and should be checked for. If you have lived outside Europe, USA or Canada in the last 5 years please list countries –

.....

Please list any serious allergies below

.....

Please book a telephone consultation with your new doctor if you have ticked any of the grey boxes and not yet been seen by any of the doctors.

Please list any operations, with dates, you have had.

.....

Are you a carer of elderly or disabled relatives? **No** **Yes**

Smoking Status please tick one

I have never smoked I am an ex-smoker – please indicate date gave up: -

I am a smoker. Please indicate how many cigarettes/ cigars you smoke per day

If you do smoke we strongly advise that you give up. We run our own “Stop Smoking” service, why not book an appointment with our practice nurse for help to stop.

Blood Pressure Status - Latest Reading: -Sys.....Dia.

If you do not have a recent measure please use our automatic BP machine and record reading here.

Height **Weight**

Alcohol Status

Scoring System

Questions	0	1	2	3	4	Your Score
How often do you have 8 (men)/6(women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Only answer the following questions if you scored 2 or more above

How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: A total score of 3+ indicates hazardous or harmful drinking and we will be contacting you to offer advice on the last 3 questions

If you are willing please indicate your ethnicity – this is a Government requirement.

Left blank we will consider as a refusal.

White Black African Black Caribbean
 White & Black Caribbean White & Black African White & Asian
 Other Mixed background Other Black Background Indian
 Pakistani Bangladeshi Chinese
 Other Asian Background Other Not willing to indicate

Please indicate first language

Signed..... Date/...../.....

For Office Use Only; Patient No..... Usual GP Already Seen by
 Consultation Booked Date..... Time..... ID Seen by..... Family History entered
 Smoking data entered BP entered Alcohol Status entered Height/Weight entered Ethnicity data entered Carer code

Form processed by Date.....