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:
(including Title)

CONTACT DETAILS FOR NEXT OF KIN:

Relationship of Next of Kin

Is your Next of Kin Registered with this Practice?

HAVE YOU EVER SERVED IN THE ARMED FORCES? **YES/NO**

If **YES** please give date of leaving Services: ....

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:
…………………………………………………………
Do you require an interpreter? YES/NO

HEIGHT …….ft …….inches

WEIGHT …….st …….lbs or ……..kg

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 The Surgery to contact you to arrange an appointment with the 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:

   Year Condition Treatment/Operation

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 …………………………..

   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:

Name of Medicine/Tablets	Dose or Strength	How many times a day?
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:

Disease	Relation	Disease	Relation
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

NOW PLEASE COMPLETE THE THE SUMMARY CARE RECORD AND THE OXFORDSHIRE CARE SUMMARY