New Patient Health Questionnaire

Welcome to Estuary Group Practice, with surgeries in Gowerton, Gorseinon and Penclawdd. For us to provide you with the best possible care, please could you complete this questionnaire (one per person). Please send copies of current medication or recent hospital letters with the registration documents.

We may also invite you to have a New Patient Check with our Health Care Assistant after receiving your registration documents. Our Administration team will book this appointment and let you know if this is required.

Please note, by providing your email and mobile number they may now, or in the future, be used for automated services e.g. SMS reminders for appointments, flu campaign reminders. Such services can be very useful for your ongoing medical care, BUT please note that any SHARED ACCESS to your email/mobile may compromise potentially confidential details (e.g. appointment arrangements). Your data is protected as per the new GDPR requirements.

Patient Details

Title	Mr		Mrs		Miss		Ms		Other (please specify)	
Surname:									Marital status:	
Date of Birth:					First Names:					
First line of home address:										
Post Code:										
Email address:										
Home Tel No:		Mobile:				Work:				
Surgery of Previous GP:										
Or, if no previous GP in the NHS, please state reason eg 'new baby' or give date first came to live in UK										

For patients under 16 years old

Please give name of legal parent(s) or guardian(s) including details (if different from above). **If under 5,** please provide details of others living at the same address with relationship to child eg John, grandfather, Jane, sister:

………
………
………

Occupation

What is your occupation? (If retired what was your last occupation?)	

Language

What is your first spoken language?	
What is your first written language?	
Do you require an interpreter?	

Religion

What is your religion?	

Disabilities

Are you registered disabled?	Yes		No	

If yes please give details of your disability:

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Medical Information

Your height:		Your weight:		Your last Blood pressure:	

Please list any serious illnesses / operations / accidents / disabilities (and for women, pregnancy-related problems) and, wherever possible, the year they took place.

Have you ever suffered from? (tick as appropriate)									
Epilepsy	Yes		No		Blindness/Glaucoma	Yes		No	
High Blood Pressure	Yes		No		Diabetes	Yes		No	
Heart Attack/Stroke	Yes		No		Asthma	Yes		No	
Cancer	Yes		No		Depression	Yes		No	
Eczema/Hay Fever	Yes		No		Any other mental illness	Yes		No	

Please can you provide any further details of these conditions, if not given above:					
Are you allergic to any medicines? If so, which ones? Eg penicillin, aspirin	Yes		No		
Are you allergic to any other allergens? Eg latex, nuts, bee stings	Yes		No		
Have you ever refused treatment/screening of any kind and, if so, what?	Yes		No		

Repeat Medication

Please list any medications being taken and the dosages (include a repeat medication slip, if possible): (Please attach proof of medication from your previous surgery. e.g. Repeat medication slip)

Which local pharmacy would you like your prescription preference to be set to (name and address)?
………
………
………

Women

Have you ever had a cervical smear?	Yes		No	

If yes, when and where was your last smear taken?
……….......................……………………………………………

Exercise

Please tick the box which best describes your level of physical activity	Exercise is impossible		Light exercise		Moderate exercise		Heavy/ competitive exercise	

Diet

Please tick the box that best describes your diet	Vegetarian		Vegan		Lactose free		Gluten free		No special diet		Other (please specify	

Smoking

Do you smoke?	Yes		No	
If no, have you ever smoked?	Yes		No	

If yes, how many cigarettes or ounces of tobacco per week?
…………………………………………….....…………

Would you like advice on giving up smoking?	Yes		No	

Drinking

Questions	Scoring System					Your Score
	0	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-3 times per month	2-3 times per week	4+ per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

For Patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or 'never'	
Have you had a pneumococcal vaccination? Enter a date or 'never'	

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease in your blood-line family:

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Other information

Do you have a carer?	Yes		No	

If yes, please ask the receptionist for a Carers consent form (or fill this out online) to be able to share medical information with you.

For Emergency contact or legal permissions

Please give name, address and telephone number of next of kin:

……
………..
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Does anyone hold Power of Attorney for you?	Yes		No		Details:
Do you hold a living will?	Yes		No		Details:

Signature: | | **Date:** |