**NEW PATIENT QUESTIONAIRE**

FAMILY MEDICAL PRACTICE

KIDGLOVE HOUSE

GOLBORNE

WA3 3GS

TEL 01942 481638

www.familymedical.gpsurgery.net

Please fill in the questionnaire openly and honestly. It will give the doctors a clearer picture of your health. It will not be used to screen patients with a view to refusing a place on the practice list. However completing the questionnaire as far as you are able is a condition of acceptance. If you have difficulty the staff will be pleased to help.

**Data Protection –** **Information held about you may be on computer. Sometimes this information is shared with other agencies within the NHS family. This is used for instance to claim fees if you want vaccinations or to tell the Health Authority of changes to your personal details (name and address etc) which we are required to give. We will never share information about you with outside agencies without your express permission. A full list of items shared on a day to day basis within the NHS is available on request. By signing this form you are agreeing to allow the sharing of this information within the NHS family.**

Name ……………………………………………..… Date of birth………………………………....

Address………………………………………………………………………………………………Post code…………….

Telephone: home….………………………..work…………..……………..mobile…………………………………

Current Medication: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**About your immediate family:-** Have any member of your immediate family ever suffered from the following?

Asthma Mother |\_| Father|\_| Brother|\_| Sister|\_|

Diabetes Mother|\_| Father|\_! Brother|\_| Sister|\_|

Heart Disease\* Mother|\_| Father|\_| Brother|\_| Sister|\_|

Cancer\*\* Mother|\_| Father|\_| Brother|\_| Sister|\_|

Other…………………………………………………………………………

Have any of your immediate family died from disease? If yes: - Please give a brief cause including age.

………………………………………………………………………………………….

\*Did the heart disease begin below the age of 60?

\*\*Where was the site of the primary cancer? **Please continue overleaf**

**About yourself:-**  Have you ever suffered from the following?

Asthma yes/no Diabetes Yes/no

Heart Disease Yes/no Cancer Yes/no

If you have answered yes to any of the above please give a brief history. Tell us about any serious illness that you suffer from or have had, including serious operations.

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**Are you currently serving, or have a history relating to military service?**

*Please circle which applies to you from the following list:*

Joined military forces/Left military service/Military Veteran/Member of military family/Member of Armed Forces/Armed Forces Reservist/ Served in Arm Forces/Dependant of former serving member of British Armed Forces/Dependent Current Serving Member of British Armed Forces

Please answer the following, if you cannot please ask a member of staff to help.

**Weight**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking**: \_\_\_\_\_\_\_\_\_\_ per day.

If you are an ex-smoker, when did you stop\_\_\_\_\_\_\_\_\_\_

**Exercise:** please indicate the type of exercise you take on a regular basis.

Regular and vigorous |\_| Irregular and vigorous |\_| Regular and Moderate |\_|

Irregular and Moderate |\_| No real exercise |\_|

How would you describe your diet? Good / Fair / Poor

**Carer:** are you an unpaid carer for a member of your family, friend, or neighbour?

YES/NO

If you help to look after someone we would like to offer you an annual health check, flu vaccine and information regarding help for Carers. Please ask at your new patient medical appointment for further information.

 **Please continue overleaf**

**Communication:**

If you have any difficulties with communication please inform the practice and we will make every effort to accommodate your needs.

**Hearing Loss** Partial |\_| Total |\_| Hearing Aids Worn |\_|

Do you use sign language? |\_|

Any other hearing issues or needs? ……………………………………………………………………………........................................................

**Sight Loss** Partial |\_| Total |\_| Do you wear glasses? |\_|

Any other sight issues or needs?

……………………………………………………………………..................................................................

**Speech** Partial |\_| Total |\_| Do you use sign language? |\_|

Any other speech issues or needs?

……………………………………………………………………………...............................................................

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**Alcohol:** Do you drink alcohol? Yes/No How many units per week? …………….

(A unit is half a pint of beer or lager, or one pub measure of spirit or one pub glass of wine).

Please complete the table below:

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

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**Please continue overleaf**

**Adult Females only**:

What method (if any) of contraception do you use?

Pill |\_| Coil |\_| Condom |\_| None |\_|

Other, please state……………………………………………………………………………………………………..

Are you on HRT? Yes / No

Have you had a Hysterectomy? Yes / No

If yes, were your ovaries also removed? Yes / No

What was the date of your last smear? .................................................................

What was the result of that smear? .................................................................

Have you had a mammogram? Yes/No

What was the result? ………………………………………………………………

**For Adults:**

**Do you have** any caring responsibilities? Yes No

Have you ever been a Looked After Child? Yes No

Do you have any learning difficulties? Yes No

Please list the names and dates of birth of any children you care for.

**…………………………………………**

**…………………………………………**

**…………………………………………**

**…………………………………………**

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**All patients/carer/guardian to sign & date:**

**Signed**………………………………………………….. **Date**………………………………

**Name & Relationship if signing on behalf of patient**…………………………………………………