**The Branston & Heighington Family Practice**
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www.branstonsurgery.co.uk

# NEW PATIENT HEALTH QUESTIONNAIRE

## PLEASE ANSWER ALL QUESTIONS THAT ARE RELEVANT TO YOU

**Welcome to our practice. It may be some time before your records reach us. The absence of these records may impair the service, which we wish to give you. It is in the interest of both yourself and your doctor that you fill in this questionnaire to the best of your knowledge.**

| **Surname** | **Forename/s** | **DoB** |
|---|---|---|
| Address | Home Phone No.<br><br>Mobile No.<br><br>Preferred Contact Number<br>Home / Mobile (please circle) | Occupation -<br><br>Religion -<br>First Language - |

Ethnic Origin (ie, White, Afrocaribbean, Asian ....................................................................................................

Have you ever been in the Armed Forces, including national service? (YES/NO)
If yes, dates From: To:

Are you a Carer? (YES/NO) If yes, details:

Does someone care for you? (YES/NO) If yes, details:

**SMS Messaging**

This is to confirm that by signing this form that I give consent for Branston Surgery to send text messages to my mobile phone. These texts will be to remind me of future appointments and for health matters relating to my treatment.

I am aware that if I change my mobile phone number, it is my responsibility to inform the surgery.

**Email Address –**

By giving the Practice my Email address I allow the Practice to contact me via email with regards to any Health Matter. The Practice has to abide by the Data Protection Act and will not release any details to a third party without your prior approval. I will inform the Practice of any change to my Email address.

**Your Named GP is – Dr Mahalingam**

Your named GP has overall responsibility for your care at the Practice however this does NOT mean you only have to see them. You can see other GP's at the Practice.

Please state any known non-drug allergies (ie animal, elastoplast):

**Women Only**

What if any, contraception form do you use?

Date of last cervical smear …………………

Have you had a Hysterectomy? YES / NO

Are you currently Pregnant? YES / NO

## Family History – Is there any history of the following in your immediate family ie Mother, Father, Brother or Sister. Please specify family member affected.

| | | | | | |
|---|---|---|---|---|---|
| Heart attack | | Heart disease | | Angina | |
| Glaucoma | | Cystic Fibrosis | | Epilepsy | |
| Diabetes | | Depression | | High blood pressure | |
| Bowel cancer | | Breast cancer | | Stroke | |
| Other please specify | | | | | |

NEW PATIENT/PARENT/GUARDIAN SIGNATURE………..……………………… Date …………………..

This form will be assessed by a Healthcare member of staff who may invite you in for an appointment to discuss any matters relating to this form however if you wish to have a New Patient Check which will involve measuring BP, weight and height and to discuss general health matters please contact the surgery.

Under our Privacy Policy – All information that is held by the Practice on you cannot be released to a third party without your written permission

**FOR HEALTH ADVICE AND INFORMATION PLEASE LOOK AT OUR WEBSITE www.branstonsurgery.co.uk**

Reviewed August 2018

**Please tick if you suffer from or have ever had any of the following conditions. Please indicate the date of your last review of this condition in the column below.**

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Asthma | | | Heart Trouble | | |
| High Blood Pressure | | | Hayfever | | |
| Angina | | | Peptic Ulcer | | |
| T.B. | | | Thyroid Disease | | |
| Bowel Trouble | | | Pneumonia/Bronchitis | | |
| Epilepsy | | | Bladder/Kidney disease | | |
| Diabetes | | | Arthritis/Joint Problems | | |
| Stroke | | | Depression/Nervous Trouble | | |
| Gynae. Problems | | | Cataracts | | |
| Glaucoma | | | Migraine | | |
| Any Cancers | | | | | |

**Are you on any repeat medication, If yes then please enclose a copy of your last prescription slip. This will help us in providing a continual supply of medication. Please be aware we are not informed of your medication needs from your previous GP.**

**PLEASE TELL US YOUR DESIGNATED PHARMACIST WHERE YOU WISH TO COLLECT YOUR MEDICATION** ........................................................................................

**Please state any known drug allergies:**

Name of Drug/s ……………………………………… Reaction ………………………………………

**Smoking Status - Please tell us if you do/do not smoke?** (please tick)

| | |
|---|---|
| A | I have never smoked |
| B | I used to smoke but I do not smoke now |
| C | I do smoke |

If you do smoke and want help in giving up smoking please contact **Quit 51** on

**0800 622 6968**

or chat to your local Pharmacist.

| Questions | Scoring System 0 | 1 | 2 | 3 | 4 | Your Score |
|---|---|---|---|---|---|---|
| How often do you have a drink that contains alcohol? | Never | Monthly or Less | 2 - 4 times per month | 2 - 3 times per week | 4+ times 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 - 9 | 10+ | |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

If you wish to discuss your alcohol intake please ask to speak to a nurse

If you have scored more than 5 on the above scoring rating and would like some information on how to cut down on your alcohol intake please ask to see a Practice Nurse for a review.

**Please circle your answer.**
**Scoring:** A total of 5+ indicates hazardous or harmful drinking

Height ……………

Weight ……………..

**Hospital Care** – Are you currently under Hospital Care – YES / NO
If YES please give details

Do you consider yourself to have a disability – YES / NO

**Detail of Impairment**

Physical Impairment – ☐
Sensory Impairment – ☐
Learning Disability/Difficulty – ☐
Mental Health Condition – ☐
Other – Please state – ☐

**When you return this form please enclose a copy of your last repeat medication slip for input onto our records.**

**Thank you**