THE ROXTON PRACTICE

Date Form Completed:	

In order to be fully registered with this practice, this form MUST be completed

NEW PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 YEARS +)					
TITLE:		**FIRST NAME:**			
SURNAME:					
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)		
MARITAL STATUS:					
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**			
		DO YOU LOOK AFTER ANYONE? **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)		
HOME TEL:		**WORK TEL:**		**MOBILE TEL:**	
EMAIL ADDRESS:					
NEXT OF KIN: (Name, Address, Tel No.)					
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	**HOME TEL:**	**YES** ☐ **NO** ☐ (please tick)			
	MOBILE TEL	**YES** ☐ **NO** ☐ (please tick)			
OCCUPATION:					
ARE YOU CURRENTLY A STUDENT?	**YES** ☐ **NO** ☐	**IF YES, WHERE?**			

HOW DID YOU FIND OUT ABOUT THE PRACTICE / DECIDE TO REGISTER WITH US?					
I've been registered here before	☐	**I have family registered here**	☐	**General word of mouth**	☐
NHS helpline or website	☐	**Non-NHS ad or weblink**	☐	**Search engine (e.g. Google)**	☐
Other (please specify):					

SMOKING HABIT				
Are you a current smoker?	**If Yes**		**If No**	
YES ☐ **NO** ☐ (please tick)	**No. Cigarettes per day?**		**Have you ever smoked?**	
	No. Cigars per day?		**If yes, what year did you stop?**	
	Pipe tobacco per week? (oz / grams)		**How many *did* you smoke per day?**	
	Would you like help to stop?	**YES** ☐ **NO** ☐		

ALCOHOL INTAKE	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick)
If Yes: Wines / Spirits: units per week	
Beer: units per week	
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer	

EXERCISE HABIT	
Do you take regular exercise?	**YES** ☐ **NO** ☐ (please tick)
If Yes: What sort : (eg. Tennis, walking)?	
For how long at any one time?	
How many times weekly?	

HEPATITIS C POTENTIAL EXPOSURE	
Do <u>any</u> of the following apply to you?	
• **had a blood transfusion or blood products in the UK before September 1991** • **ever injected drugs (including anabolic steroids), even if it was only once or twice, or many years ago** • **you are the child of a mother with hepatitis C.** • **you are the sexual partner of someone with hepatitis C** • **had medical or dental procedures, ear piercing, body piercing, a tattoo, acupuncture or electrolysis abroad, in countries where infection control may be poor** • **been accidentally exposed to blood where there is a risk of hepatitis C infection** • **have previously been diagnosed with non-A, non-B hepatitis and not subsequently tested for hepatitis** • **have had unexplained abnormal liver function tests (e.g. elevated ALT), or unexplained jaundice**	If the answer to *any* of these questions is yes, please indicate YES below: **YES** ☐ **NO** ☐

MEDICATION

ARE YOU ON ANY REGULAR MEDICATION? **(inluding the contraceptive pill)**	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state name and dose:

(Please note you will be required to see the doctor for a first repeat prescription to be issued)

ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state type and name:

WOMEN ONLY

Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Addictions (Legal and/or illegal substances)	**YES** ☐ **NO** ☐		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐

If Yes, Please give details:

Please give details of the current state of your family's health:

	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Sibling(s)				

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME _____ **DOB** _____

What is your main language? | |

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	
English	
Welsh	
Northern Irish	
British	
Irish	
Gypsy/Traveller	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	
Indian, Indian Scottish or Indian British	
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	
Chinese, Chinese Scottish, or Chinese British	
Other Asian, please specify:	

D. African	
African, African Scottish, or African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	
Black, Black Scottish, Black British	
Other Caribbean or Black, please specify:	

F. Other ethnic group	
Arab	
Other, please specify:	

If you would prefer not to provide this information, please tick here:	
If you don't know your ethnicity, please tick here:	