New Patient Health Questionnaire for Adults

Your Contact Details

Title
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname

Date of Birth

First Names

Occupation

Previous Surnames

Home Address

Postcode:

Home Tel
Mobile

Email
Please provide an email address where possible

Information about you

What is your height?
What is your weight?

What is your first language? **Interpreter needed YES/NO**

Ethnic Group

White British ☐ Irish ☐ Other ☐ Please State:

Black Caribbean ☐ African ☐ Other ☐ Please State:

Asian Indian ☐ Pakistani ☐ Chinese ☐
Other ☐ Please State:

Mixed White + Black ☐ Caribbean White + Black African ☐
White + Asian ☐ Other ☐ Please State:

Have you ever suffered from? (tick as appropriate)

Anxiety	Yes / No	Depression Yes / No	
OCD	Yes / No	Bipolar Disorder Yes / No	

Do you have any other mental health issues? (If yes please give details)

Are you receiving or have you received any treatment or therapy? (If yes please give details)

Have you ever refused treatment/screening of any kind and if so, what?
Yes / No

Exercise

Do you take regular exercise YES / NO

If yes what sort of exercise

How many minutes do you typically spend on the exercise per session

How many times per week do you exercise

Medical Information

Please list any serious illnesses / operations / accidents / disabilities (for women any pregnancy related problems) and the year they took place:

Have you ever suffered from?

Epilepsy	Yes / No	Blindness/Glaucoma	Yes / No
High Blood Pressure	Yes / No	Diabetes	Yes / No
Heart Attack/Stroke	Yes / No	Depression	Yes / No
Cancer	Yes / No	Asthma	Yes / No
Eczema/Hay Fever	Yes / No	COPD	Yes / No

Please list any medicines being taken and the amount:

Are you registered disabled? Yes / No (If yes, please give details)

Are you allergic to any medicines and if so, which?
Yes / No

Carers

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

Smoking

Do you smoke? Yes / No

If 'No', have you ever smoked? Yes / No **When did you stop?**

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke?
Cigarettes /daily Cigars /daily Rolled Tobacco /ounces/grams daily

Would you like advice on giving up smoking? Yes / No

Women
Have you ever had a cervical smear? Yes / No
(Please state the last date)

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

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

Alcohol

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No ☐ Yes, on one occasion ☐ Yes, more than once ☐

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.)

Next of Kin

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

For all new Patients – if you would like to have a new patient check with the treatment room please request a new patient check via reception. *Patients over 75 are entitled to request a yearly health check Please discuss with reception*

<u>Latent TB Questionnaire</u>

Please circle either Yes or NO to the following questions

Were you born or have spent more than 6 months living in any of The countries listed below	**YES / NO**
Have you entered the UK within the last 5 years?	**YES / NO**
Are you aged between 16 and 35 years of age	**YES / NO**
Have you a History of TB either treated or untreated	**YES / NO**
Have you ever been screened for TB in the UK	**YES / NO**

List of Countries with a High Incidence of TB Tick the one that applies to you (if none – then do not tick any box)

	Tick		Tick		Tick		Tick
Afghanistan		DR Congo		Madagascar		Rwanda	
Angola		Equatorial Guinea S		Malawi		São Tomé and Principe	
Bangladesh		Eritrea		Mali		Senegal	
Benin		Ethiopia		Marshall Islands		Seychelles	
Bhutan		Gabon		Mauritania		Sierra Leone	
Botswana		Gambia		Mauritius		Somalia	
Burkina Faso		Ghana		Micronesia		South Africa	
Burundi		Greenland		Mongolia		Sudan (South)	
Cambodia		Guinea		Mozambique		Swaziland	
Cameroon		Guinea Bissau		Myanmar		Thailand	
Cape Verde		Haiti		Namibia		Togo	
Central African Republic		India		Nepal		Tuvalu	
Chad		Indonesia		Niger		Uganda	
Comoros		Kenya		Nigeria		Tanzania	
Congo		Kiribat		Pakistan		Zambia	
Côte d'Ivoire		Lao PDR		Papua New Guinea		Zimbabwe	
Djibouti		Lesotho		Philippines			
DPR Korea		Liberia		Republic of Moldova			

Signature:

Date: