NEW PATIENT HEALTH QUESTIONNAIRE

ST. THOMAS & WEST CROSS MEDICAL CENTRES

Dear Patient

As a newly registered patient of St. Thomas & West Cross, we would be grateful if you could complete this questionnaire. This will allow us to provide you with excellent medical care.

If you have any questions regarding this questionnaire or any other matter, please speak with a receptionist, they will be happy to answer your queries.

ALL INFORMATION THAT YOU GIVE IS COMPLETELY CONFIDENTIAL

PERSONAL INFORMATION

Please tick relevant box

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname: Gender: Male ◯ Female ◯

Forename(s): Date of Birth: / /

Address:

Post code:

Home Tel:

Mobile Tel:

Email Address

Marital Status: Please tick relevant box

Married / living with partner ◯ Single ◯

Divorced / separated ◯ Widowed ◯

Next of Kin:

Name Relationship:

Contact Tel No.:

DISABILITY ACCESS NEEDS/SENSORY LOSS/CARER

Do you consider yourself to have a disability Yes ◯ No ◯

If yes, please specify the nature of the disability

Is there any other information relating to your disability that the Practice needs to be aware of?
i.e. Wheelchair use, use of walking aid, Need to attend with carer / helper etc.

Do you suffer with Sensory Loss? Yes ◯ No ◯

If yes, please specify what you require support with (e.g. hearing loss, visual impairment, speech/language difficulties)

Please specify which Language you prefer to be communicated in.

Are you a carer? Yes ◯ No ◯

If yes, is the person you care for our patient? Yes ◯ No ◯

Patient Details (name, dob, address etc):

VETERANS

Do you / have you ever served in the armed forces? Yes ◯ No ◯

(Office use only – If Yes Please read-code 13q3)

MEDICAL INFORMATION

Have you ever suffered from the following illnesses?

Diabetes	Yes ○	No ◉	If yes, date of diagnosis
High blood pressure	Yes ○	No ◉	If yes, date of diagnosis
Coronary Heart Disease	Yes ○	No ○	If yes, date of diagnosis
Asthma	Yes ○	No ○	If yes, date of diagnosis
Chronic Bronchitis	Yes ○	No ○	If yes, date of diagnosis
Epilepsy	Yes ○	No ○	If yes, date of diagnosis
Cancer	Yes ○	No ○	If yes, date of diagnosis
Thyroid Disease	Yes ○	No ○	If yes, date of diagnosis
Severe Mental Health Disorder	Yes ○	No ○	If yes, date of diagnosis
Kidney Disease	Yes ○	No ○	If yes, date of diagnosis
Atrial Fibrillation	Yes ○	No ○	If yes, date of diagnosis

Have any close relatives had heart disease or stroke before aged 55 years?

Yes ◯ No ◯ If yes please provide details

When was your blood pressure checked?

Women Only: The date of your last smear?

Are you on medication and / or receiving any treatment at present for any medical condition?

Yes ◯ No ◯

Current Weight: Height:

Do You Smoke? Yes ◯ No ◯ Ex ◯

If yes how many per day?

If ex-smoker – when did you stop smoking?

Would you like to receive smoking cessation information? Yes ◯ No ◯

Do you drink alcohol? Yes ◯ No ◯

If yes, how many units per week?