

## Heaton Medical Centre New Patient Health Questionnaire

Forename:	Surname:
Address:    Postcode:	Date of Birth:
	Home Tel:
	Mobile Tel:
	Work Tel:

### Medical Information

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

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Have you ever suffered from? (tick as appropriate)

Epilepsy <input type="checkbox"/>	Blindness/Glaucoma <input type="checkbox"/>
High Blood pressure <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Heart Attach/Stroke <input type="checkbox"/>	Depression <input type="checkbox"/>
Cancer <input type="checkbox"/>	Asthma <input type="checkbox"/>
Eczema/Hay fever <input type="checkbox"/>	COPD <input type="checkbox"/>

Please list any medicines being taken and the amount: (use extra paper if required)

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Are you registered disabled? (if yes please give details)

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Are you allergic to any medicines and if so, which?

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Do you have a carer? (if yes please give details)

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Are you are carer? (if yes please give details)

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Have you ever had a cervical smear? (if yes please state when and where)

Do you smoke?

If no, have you ever smoked?

If you currently smoke, how many cigarettes or ounces of tobacco per day?

Would you like any advice on giving up?

Alcohol

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

How many units per week do you drink? \_\_\_\_\_

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease (mother/father/brother/sister).

For patient aged 65 and over

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

Have you had a flu vaccination? (enter date or 'never') \_\_\_\_\_

Have you had a Pneumococcal vaccination? (enter date or 'never') \_\_\_\_\_

**Ethnic Group**

White British  Irish  Other \_\_\_\_\_

Black Caribbean  African  Other \_\_\_\_\_

Asian Indian  Pakistan  Chinese  Other \_\_\_\_\_

Mixed White & Black Caribbean  White & Black African

White & Asian  Other \_\_\_\_\_

Language

**Summary care record**

I have read the information supplied.

I wish to have an NHS Summary Care Record

I decline to have an NHS Summary Care Record

Signature \_\_\_\_\_ Date \_\_\_\_\_