Attleborough Surgeries

Confidential Health Questionnaire

New Patients Over 16

We welcome new patient registrations. Please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Please check the form carefully and give us as much information as you have available. Items marked with an asterisk (*) are mandatory. Information will be treated as strictly confidential.

Title* ___ ***Surname**** ___ ***Date Of Birth**** ___ / ___ / ___

First Name(s)* ___ ***Marital Status*** ___

Previous Surnames(s) ___

Address* ___

___

___ ***Post Code**** ___

Home Tel.* ___ ***Work Tel.*** ___ ***Mob. Tel.*** ___

Email Address ___

Town & Country Of Birth ___

First Language ___ ***Do you need an interpreter?*** ***Yes*** ☐ ***No*** ☐

Ethnicity (Please tick the description you feel is most appropriate). If you do not wish to provide this, please tick Information Refused at the bottom of the list.

White-British	☐	***White-Irish***	☐
Other-White Background	☐	***Mixed-White and Black Caribbean***	☐
Mixed-White and Black African	☐	***Mixed-White and Black Asian***	☐
Other-Mixed Background	☐	***Asian or Asian British-Pakistani***	☐
Asian or Asian British-Bangladeshi	☐	***Other Asian Background***	☐
Chinese	☐	***Other Ethnic Background***	☐

Information Refused ☐

Next of kin, their relationship to you and their telephone no.

___

Present occupation ___

Which of these best describes the kind of <u>Exercise</u> you take? (Please tick one)					
Impossible due to poor health ☐	***None*** ☐	***Light*** ☐	***Moderate*** ☐	***Strenuous*** ☐	***Competitive Athlete*** ☐
How many times do you exercise per week?					

<u>Smoking Status*</u> *(Please tick the statement that is applicable to you.)*	***Never smoked*** ☐	***Current Smoker*** ☐ *How many cigarettes/cigars or how much pipe tobacco do you smoke per day?*	***Stopped Smoking*** ☐ *What was the date you stopped smoking?*

<u>Alcohol Consumption*</u> (Please tick one answer for each question)
1 drink = 1/2 pint of beer or 1 glass of wine or single measure of spirit.

1. How often do you have a drink containing alcohol?

Never	*Monthly or less*	*2-4 times a month*	*2-3 times a week*	*4 or more times a week*
☐	☐	☐	☐	☐

2. How many standard drinks containing alcohol do you have on a typical day?

1 or 2	*3 or 4*	*5 or 6*	*7 or 9*	*10 or more*
☐	☐	☐	☐	☐

3. How often do you have six or more drinks on one occasion?

Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*
☐	☐	☐	☐	☐

Have you had your blood pressure checked in the last 3 years? ***Yes*** ☐ ***No*** ☐

Do you have any known allergies? ***Yes*** ☐ ***No*** ☐

If yes, please give details.

Do you suffer with, or is there a family history of, any of the following? Please tick if yes.		
	You?	***Family member? - please state relationship to you***
Coronary/Ischaemic Heart Disease	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
Stroke/TIA	☐	☐
High Blood Pressure (Hypertension)	☐	☐
Type 1 or 2 Diabetes	☐	☐
Glaucoma	☐	☐
Asthma	☐	☐
Chronic Obstructive Pulmonary Disease	☐	☐
Chronic Lung Disease	☐	☐
Eczema	☐	☐
High Cholesterol	☐	☐
Epilepsy	☐	☐
Hypothyroidism	☐	☐
Cancer	☐	☐
Mental Illness/Psychosis	☐	☐

Do you currently take any medication and if so what is it for?

Yes ☐ ***No*** ☐

If yes, please give details.

Have you had any surgical procedures? ***Yes*** ☐ ***No*** ☐ ***If yes, please give details below.***

Date	***Surgical Procedure***	***Hospital***
/ /		
/ /		
/ /		

For Female Patients Only

Would you like to register for contraception? ***Yes*** ☐ ***No*** ☐

If you use contraception, state method

Have you ever had a smear? ***Yes*** ☐ ***No*** ☐

If yes, what was the date of your last test if known?

Have you had a hysterectomy? ***Yes*** ☐ ***No*** ☐

If yes, please supply the date if known.

Have you ever had a mammogram? ***Yes*** ☐ ***No*** ☐

If yes, please supply the date if known.

Are you currently pregnant? ***Yes*** ☐ ***No*** ☐

If yes, expected delivery date.

Patient Declaration

There is a balance between privacy and good health care. Unless we receive your written instructions to the contrary, we will normally share some information with other health care professionals involved in your care, such as doctors, nurses, therapists and pharmacists.

I confirm the information provided on this form is correct and agree to the Practice terms on information sharing.

Signed*

Date* / /

Office Use only:

EMIS Number ***Date of registration and entry onto EMIS*** / /

Identification Type: