Waterloo Medical Centre

**New Patient Health Questionnaire**

**Patient Details**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Mr |  | Mrs |  | Miss |  | Ms |  | Surname |  |
| Date of Birth |  | First Names |  |
| Occupation |  | Previous Surnames |  |
|  |
| Home Address: |
|  |
|  |
| Post Code: |
|  |
| Tel No: Home  | Mobile: | Work: |

|  |
| --- |
| Email Address: |
| Name and Address of Previous GP: |

**Ethnic Group**

|  |  |  |  |
| --- | --- | --- | --- |
|  | White |  | British |
|  |  | Irish |
|  |  | Other (Please specify) |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Black |  | Caribbean |
|  |  | African |
|  |  | Other (Please specify) |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Asian |  | Indian |
|  |  | Pakistani |
|  |  | Chinese |
|  |  | Other (Please specify) |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mixed |  | White & Black Caribbean |
|  |  | White & Black African |
|  |  | White & Asian |
|  |  | Other (Please specify) |  |

|  |  |  |
| --- | --- | --- |
| **Language** | What is your first language? |  |
|  | Do you need an interpreter? | Yes/No |

|  |  |  |
| --- | --- | --- |
| Religion |  | Christian |
|  | Islam |
|  | Hinduism |
|  | Buddhism |
|  | Sikhism |
|  | Judaism |
|  | Other (Please specify) |  |

**Marital Status**

|  |  |
| --- | --- |
|  | Single |
|  | Married |
|  | Cohabiting |
|  | Divorced |
|  | Widowed |

**Next of Kin**

Name………………………………….. …….. Contact No. …………………………………………Relationship ………………..

May we contact your next of kin in the event of an emergency?

**Other information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you an ex-Veteran** | Yes |  | No |  |

If yes, do you need assistance with care / social care services ? ………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have a carer? | Yes |  | No |  |

If yes, please give details of your carer: ………………..…………………………………………………………………………..

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you a carer? | Yes |  | No |  |

If yes, please give details of who you care for: ………..…………………………………………………………………………..

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you registered disabled? | Yes |  | No |  |

If yes please give details of your disability: ………………………………………………………………………………………..

**Equal Opportunities**

Which of the following options best describes you?

|  |  |
| --- | --- |
|  | Woman (including trans woman) |
|  | Man (including trans man) |
|  | Non-binary |
|  | In another way (Please state) |  |

Is your gender identity the same as that you were assigned at birth?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

Which of the following options best describes how you think of yourself?

|  |  |
| --- | --- |
|  | Lesbian |
|  | Bisexual |
|  | Gay |
|  | Heterosexual/Straight |
|  | In another way (Please state) |  |

**Equality and Diversity Policy**

Our policy is designed to ensure and promote equality and inclusion, supporting the ethos and requirements of the Equality Act 2010 for all visitors of our practice.

We are committed to:

* ensuring that all visitors are treated with dignity and respect
* promoting equality of opportunity between men and women
* not tolerating any discrimination or perceived discrimination against, or harassment of, any visitor for reason of age, sex, gender, marital status, pregnancy, race, ethnicity, disability, sexual orientation, religion or belief
* providing the same treatment and services (including the ability to register with the practice) to any visitor irrespective of age, sex, marital status, pregnancy, race, ethnicity, disability, sexual orientation, medical condition, religion or belief

This policy applies to the general public, including all patients and their families, visitors and contractors

Please list any medications being taken and the dosages:

|  |
| --- |
|  |

**Medical Information**

|  |
| --- |
| Please list any serious illnesses/operations/accidents/disabilities (and for women, pregnancy related problems) and the year they took place. |
| Have you ever suffered from? (tick as appropriate) |
| 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 |  |  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever had a cervical smear? | Yes |  | No |  |

If yes please state when and where: ………..……………………………………………………………………………………….

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? | Yes |  | No |  |
| If no, have you ever smoked? | Yes |  | No |  |

If yes how many cigarettes or ounces of tobacco per week? ………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Would you like advice on giving up smoking? | Yes |  | No |  |

|  |  |  |
| --- | --- | --- |
| How much alcohol do you drink in a week? |  | units |
| (1 unit = ½ pint beer, 1 small glass of wine, 1 single spirit, 1 small glass of sherry or 1 single aperitif) |

**OVER 16’s ONLY**

**Alcohol Users Disorders Identification Test (AUDIT) C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring System** | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-3 times per month | 2-3 times per week | 4+ per week |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Your height: |  |  |  | Your weight: |  |  |  |

**Family History**

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease:

………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………..

**Proof of Identity**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Birth Certificate  |  | Driving Licence |  | Passport |  | Utility Bill |
|  | Allowance Book |  | Solicitor’s Letter |  | Offer of Tenancy |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

**Please bring this questionnaire with you when you attend for your appointment, along with your proof of identity, or your registration cannot be accepted.**

**If you wish to register for on-line services please ensure you have entered your email address on this form.**

***All Information supplied will be treated in the strictest of confidence and all staff adhere to the Code of Confidentiality***.

Thank You

*STAFF ONLY*

ID SEEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEEN BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_