THE VILLAGE SURGERY - Southwater

ADULT NEW PATIENT HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible and let us have it back before your new patient health check appointment with one of the Nursing Team.

Your answers will be treated in the strictest confidence but will allow us to ensure continuity of health care until your medical records arrive from your previous surgery.

Full Name: …… **Date of Birth**: ……. /……. /…….

Address ……

……

Postcode ……..

Occupation: ..... **Marital Status:** .....

Home Tel No: ..... **Mobile Tel:** .....

Email address.....

Emergency Contact **Name & Tel Number**.....

Next of Kin Contact **Name & Tel Number**.....

Do you consent to being contacted by email and text when the facility is available? **Yes / No**

YOUR HEALTH

What is your HEIGHT:		
What is your WEIGHT:		
Do you suffer, or have you ever suffered, from any of the following conditions? Please tick as appropriate	**Yes**	**No**
Asthma		
COPD		
Diabetes		
Epilepsy		
Thyroid problems		
Stroke		
Mental Health problems		
Heart Disease/Attack		
High Blood Pressure		
Cancer		

Are you taking any medication for any of the above? If "Yes" please give details below:

THE VILLAGE SURGERY – Southwater

ALLERGIES		
Do you suffer from any allergies?	**Yes**	**No**
If **Yes**, please indicate here what sort of allergy/allergies:		

BLOOD PRESSURE	
When did you last have your blood pressure measured?	Date:
What was the last reading, if known?	

QUESTIONS FOR WOMEN ONLY	Yes	No
Are you currently pregnant?		
Have you had a **total abdominal hysterectomy**?		
If so, what was the date?		
What was the date of your last smear?		

FAMILY HISTORY

Have you or any of your blood relatives had any of the following problems? Specifically:
Mother, father or brother/sister

	Yes	No	Relative/Self	Age
Heart attack				…….....years
Stroke				
High blood pressure				
Raised cholesterol level				
Diabetes				

SMOKING		
1. Have you ever smoked	**No**	**Yes** see questions 2 & 3

2. I am an ex-smoker ☐ Date started.....	Date stopped.....
3. I am a current smoker ☐ .....cigarettes/cigars a day .....oz pipe tobacco a day	Date started.....

I would like to give up	**Yes**	**No**

Giving up smoking will greatly benefit your health. Our Nursing Team includes a trained Smoking Cessation Adviser.

Please tick here if you would like to give up smoking and see one of our Nursing Team for advice ☐

THE VILLAGE SURGERY – Southwater

LIFESTYLE

Please complete the following sections about your lifestyle. Your answers will help us to provide you with the most appropriate advice and ongoing health care.

				
Pint of Regular Beer/Lager/Cider 2 units	Alcopop or Can of Lager 1.5 units	Glass of Wine (175mls) 2 units	Single Measure Of Spirits 1 unit	Bottle of Wine 9 units

Thinking about what you drink ….. please ring the appropriate answers and enter your score* below

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 - 4 times per month	2 - 3 times per week	4+ times Per week	
How many units do you have on a typical day when you are drinking?	1 – 2	3 - 4	5 – 6	7 – 9	10 +	
How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total *	

***If your score is 5 or above please answer the following questions**

Questions	Scoring System					Your score
	0	1	2	3	4	
How often during the past year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the past year have you failed to do what was normally expected of your because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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 or almost daily	
Have you or somebody else been injured as a result of your drinking?	No	Yes, but not in the last year		-	Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No	Yes, but not in the last year		-	Yes, during the last year	
					Total*	

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EXERCISE

1. Please tell us the type and amount of physical activity involved in your work

		Please tick ONE box only
A.	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
B.	I spend most of my time at work sitting (such as in an office)	
C.	I spend most of my time at work standing or walking. However my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
D.	My work involves definite physical effort including handling of heavy objects and the use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
E.	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the **last week**, how many hours did you spend on each of the following activities?
Please answer whether you are in employment or not

		Please tick one box only on each row			
		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
B	Cycling, including cycling to work and during leisure time				
C	Walking, including walking to work, shopping, for pleasure etc				
D	Housework/childcare				
E	Gardening/DIY				

3. How would you describe your usual walking pace? Please tick one box only.

Slow Pace ☐ Steady average pace ☐

Brisk Pace ☐ Fast Pace i.e. over 4 mph ☐

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CARERS

A carer is defined as someone, irrespective of age, who provides or supervises a substantial amount of care on a regular basis to someone who is unable to manage on their own due to illness, disability, frailty, mental distress or impairment.

Are you registered with the practice as a carer?	**Yes / No**
Who do you care for? Please give name & relationship	
Is he or she a patient at this practice?	**Yes / No**

POULTRY

Do you work with or come into close contact with poultry?	**Yes / No**
If you do you may be entitled to a free annual 'flu vaccination'	

If you would like an appointment to discuss the content of your health questionnaire with a health care assistant, please book an appointment.

THE VILLAGE SURGERY - Southwater

REGISTRATION INFORMATION - Ethnicity and Language

✓ Please tick your ethnic category

- ☐ British (White)
- ☐ Irish (White)
- ☐ Any Other White Background (White)
- ☐ White and Black Caribbean (Mixed)
- ☐ White and Black African (Mixed)
- ☐ White and Asian (Mixed)
- ☐ Any Other Mixed Background (Mixed)
- ☐ Indian (Asian or Asian British)
- ☐ Pakistani (Asian or Asian British)
- ☐ Bangladeshi (Asian or Asian British)
- ☐ Any Other Asian Background (Asian or Asian British)
- ☐ Caribbean (Black or Black British)
- ☐ African (Black or Black British)
- ☐ Any Other Black Background (Black or Black British)
- ☐ Chinese (Other Ethnic Groups)
- ☐ Any Other Ethnic Group
- ☐ Not Stated

☐ **If other please state:** ……..

✓ Please tick your first or preferred language:

- ☐ Arabic
- ☐ Bengali
- ☐ British Sign Language
- ☐ Chinese Yue
- ☐ English
- ☐ Parsi
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Non verbal communication
- ☐ Any Other Language
- ☐ Italian
- ☐ Japanese
- ☐ Kurdish
- ☐ Makaton
- ☐ Mandarin Chinese
- ☐ Patois/Creole
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Somali
- ☐ Spanish
- ☐ Swahili
- ☐ Tamil
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Welsh
- ☐ Gujerati

☐ **If other language please state:** ……..……

The ethnic category and languages used above are as defined by and collected at the request of the Department of Health, the Gloucestershire Primary Care Trust and are assured by the Information Standards Board for Health and Social Care.