

New Patient Health Questionnaire for Adults

Patient Details

Title	Mr/Mrs/ Miss/Ms/other	Surname	
Date of Birth		First names	
Occupation		Previous surnames	
Home Address		Post code	TQ
		Telephone	01803
Marital status; single/married/divorced/separated/co-habiting/widowed			

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

Proof of Identity and Address Provided?

Birth Certificate	Diving Licence	Passport	Utility Bill
Allowance Book	Solicitor's Letter	Offer of Tenancy	Other please specify

Please give name, address & telephone number of your next of kin	If you have changed GP's previously within the last year please give details of previous GPs you have been registered with and dates	First Spoken language

I give my consent for the medical team to contact my next of kin in the case of an emergency Signature :	Date:
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Email Address:.....

We offer appointment booking, repeat prescription ordering and change of personal detilas via the internet if you would like to be able to do this please tick the box and we will provide you with a user number and pin.

Please note that by supplying your email address you will automatically be included in our virtual patient survey if you **do not wish to be included please tick the box

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or 'never'	
Have you had a pneumococcal vaccination? Enter date or 'never'	

Withycombe Lodge Surgery

What is your Smoking Status? Please circle If you smoke how many cigarettes a day?	Smoker Ex-Smoker Never-Smoked
What is your Height?	Metres: Centimetres:
What is your Weight?	Kilogram's:
Blood Pressure: If you monitor your blood pressure at home, what was your last recording?	<input type="text"/> over <input type="text"/>
Do you regularly care for someone who is disabled or chronically ill? Please Circle	No Yes

Medical Conditions:

Do you have or have ever suffered from any of the following: (Please tick all that apply)

Asthma	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Angina	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Mental Illness (Excluding Depression)	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Other:	

Has any (blood) relative ever suffered from any of the following: (Please tick & state relationship)

Asthma	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Angina	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Mental Illness (Excluding Depression)	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Other:	



How many units of alcohol do you have per week?

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 - 4 times per month	2 - 3 times per week	4+ times 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 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking