WELCOME TO DR GUINDY & PARTNERS, ORCHARD & ENDON SURGERIES

NEW PATIENT HEALTH QUESTIONNAIRE

The information you provide will help the doctor to make an initial assessment of your health which will help in your future treatment. You may be invited to attend a routine Health Screening appointment shortly, this appointment will be with the Healthcare Support Worker
Please complete this questionnaire as fully as possible

SURNAME		**FIRST NAMES**	.....
ADDRESS	.....	**MARITAL STATUS**	.....
	.....	**D.O.B.**	.....
POST CODE	.....	**TEL NO. HOME**	.....
		MOBILE TEL NO	.....
WEIGHT	.....	**HEIGHT**	.....
Occupation	.....		

PLEASE INDICATE IF YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS

		Date Diagnosed
Hypertension (High Blood Pressure)	☐	.....
Stroke	☐	.....
Heart Disease (if yes please indicate type if known)	☐	.....
Asthma	☐	.....
Epilepsy	☐	.....
Diabetes	☐	.....
Others	☐	.....
Operations (If yes, please give details)	☐	

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PLEASE NOTE -
Please provide a copy of your most recent prescription counterfoil so that your medications can be issued to you as promptly as possible. Failure to do so may result in a delay in your receiving regular medication.

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (Heart attacks, angina) Yes / No. Which family member?_____

Stroke? Yes / No. Which family member?_____

Cancer? Yes / No. Which family member?_____

Site of cancer?_____

Diabetes Yes / No Which family member? _____

CARERS

Do you have anyone who looks after you or your daily needs as Carer? Yes / No

If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)

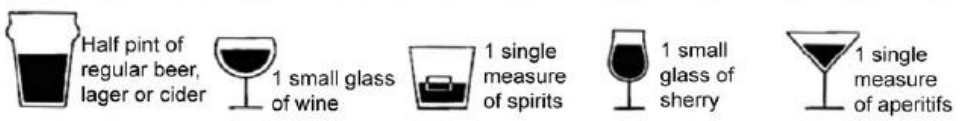
Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

ADULT FEMALES ONLY

Date of last Cervical Smear Test if known ……..

ALCOHOL

This is one unit of alcohol…



…and each of these is more than one unit

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last 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 last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an	Never	Less than	Monthly	Weekly	Daily or	

alcoholic drink in the morning to get yourself going after a heavy drinking session?		monthly			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	

Scoring 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

SMOKING

Please choose from the following options:

Never Smoked □

Ex Smoker **(if so date stopped approx)** □ ..... Date stopped

Smoker **(if so how many per day).** □ ..... How many per day

If you would like smoking cessation advice

please tick the box and someone will contact you □

EXERCISE

Please give an indication of your level of average exercise.

Light □ Moderate □ Heavy □

ALLERGIES

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The Department of Health has asked us to record the ethnic origin of all new patients.

This information will be added to your medical record.

ETHNIC ORIGIN (please tick the description which you feel is most appropriate.

White - British
White – Irish
Other White Background (please state)
Mixed – White & Black Caribbean
Mixed – White & Black African
Other Mixed Background
Asian or Asian British – Indian
Asian or Asian British - Pakistani
Asian or Asian British – Bangladeshi
Other Asian Background
Black or Black British - Caribbean
Black or Black British – African
Other Black Background
Chinese
Other Ethnic Background
Information Refused

Main Language Spoken

Thank you for completing this information. Please return this form to reception together with a copy of your most recent prescription counterfoil (if applicable).