

# Health questionnaire for new patients

## your full name



.....

female       male

## your address

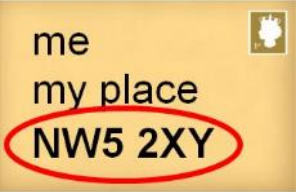


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.....

.....

## your postcode



.....

## your phone number(s)



home.....

mobile.....

work.....

## your date of birth



.....

## married or single



I am married.....

I have a partner (not married).....

I am single.....

do you have a job?



yes  no

my job is.....

how much do you weigh?



kg

stone  
 pounds

how tall are you?



cm

feet  
 inches

your blood pressure



.....

your place of birth (town | country)



..... | .....

languages you speak



your first language.....

other language(s).....

.....

### your ethnicity (where your family is from)



.....

### do you need an interpreter?



yes

no

### if you are under 16 years old



name of your parent(s) or carer(s)

.....

### their relationship to you



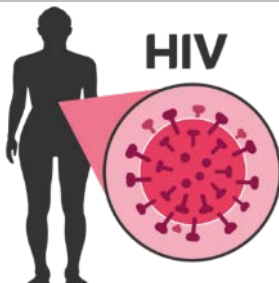
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### the name of your school



.....

### if you are over 16 years old



you can have an HIV test – would you like to have one?

yes

no

If yes, please let reception know and tell them if you would prefer to have the test at the Royal Free or the Whittington Hospital

- They will fill out a **blood test form** for you
- Take it the hospital you've chosen between **9am** and **4.30pm**, **Monday** to **Friday**, and they will take blood for the test

### if you are over 16 years old



you can have a sexual health test – would you like to have one?

yes

no

If yes, please ask reception to book this with the nurse

### if you are over 75 years old



you can have a health check – would you like to have one?

yes

no

If yes, please ask reception to book this with the doctor and health care assistant (HCA)

### next of kin details



name of your next of kin

.....

their contact details

.....

### their relationship to you



.....

**do you smoke?**



yes

no

**if yes, how many do you smoke?**



cigarettes per day.....

cigars per day.....

other (e.g. pipe).....

**at what age did you start smoking?**



years old

**ex-smokers**

**at what age did you stop smoking?**



years old

**how many did you smoke per day?**



.....

**passive smoking**

**do people smoke around you?**



at work    yes   

no   

at home    yes   

no

**diet**

**do you add salt to your food after cooking?**



yes

no

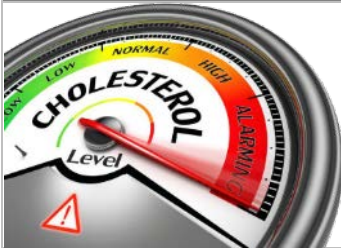
**do you have a varied diet that includes milk, meat, vegetables and fruit?**



yes

no

**has your cholesterol been checked in the last 2 years?**



yes

no

**exercise**

**do you take regular exercise?**



yes

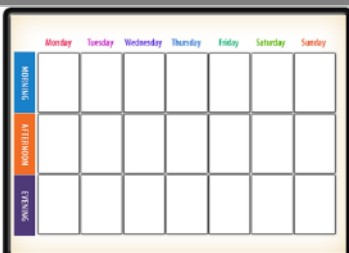
no

**if yes, what kind of exercise?**



.....

**how many times per week?**



.....



**allergies – are you allergic to anything?  
(for example, food, medicines, bee stings)**



yes

no

**if yes, please give details below**



.....  
 .....  
 .....  
 .....

**alcohol  
alcohol unit information**



1 pint of beer or lager or cider = **2 units**



1 alcopop or 1 can of lager = **1½ units**



1 glass of wine (175ml) = **2 units**



1 single measure of spirits = **1 unit**



1 bottle of wine = **9 units**

follow along the row to work out your score for each question and add this number to the last column	working out your score					your score
	0	1	2	3	4	
how often do you have a drink that has alcohol in it?	never	once a month or less	2-4 times per month	2-3 times per week	4+ times per week	
how many alcoholic drinks do you have on a normal day when you are drinking?	1-2	3-4	5-6	7-8	10+	
how often do you have 6 or more alcoholic drinks on 1 occasion?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
how often in the last year have you found that you couldn't stop drinking once you'd started?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
how often in the last year have you not managed to do what you were supposed to do because of drinking?	never	less than once a month	once a month	once a week	everyday or nearly everyday	
has a family member/friend/doctor or worker been worried about your drinking or asked you to drink less?	no		yes but not in the last year		yes, during the last year	

if your score is **5 or more**, you may be drinking too much alcohol



**please tell us about any medicines you take (whether or not these are prescribed)**



name of medicine.....

dosage (amount you take).....



name of medicine.....

dosage.....

name of medicine.....

dosage.....

name of medicine.....

dosage.....

name of medicine.....

dosage.....

**female patients only**  
**date of your most recent cervical smear**



.....

**where did you have the smear test done?**



.....

**what was the result of the smear test?**



normal

abnormal

**pregnancy - please tell us about any complications, miscarriages, terminations**



.....  
.....  
.....  
.....  
.....  
.....

**what contraception are you using now?**



.....

### carers – do you have or need a carer?



yes

no

**if yes, would you like your carer to deal with your health matters at the GP's?  
(the receptionist can help arrange this)**



yes

no

### are you a carer for anyone else?

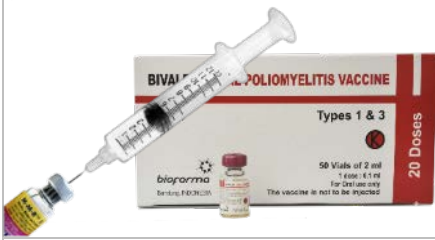


yes

no

if yes, ask the receptionist about support for carers

## record of vaccination dates



type of vaccination	1st	2nd	3rd	booster
Diphtheria/Polio/HIB				
Meningitis C				
BCG				
MMR				

### if MMR was given separately, please list details below

Measles				
Mumps				
Rubella (German Measles)				
Tetanus				
Typhoid				
Yellow Fever				
Cholera				
Hepatitis A				
Hepatitis B				
Hepatitis C				

### please tell us about any other vaccinations below


**your medical history**  
**have you ever been admitted to hospital?**



yes

no

**what were you in hospital for?**



.....

.....

.....

.....

.....

**please tell us about any treatment you've had for chronic (long-term) conditions**



.....

.....

.....

.....

.....

**X-rays, scans, ultrasound, mammogram**  
**Please give dates below**



**X-rays**

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**MRI scans**

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**CT scans**

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**Mammogram**

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**Ultrasound**

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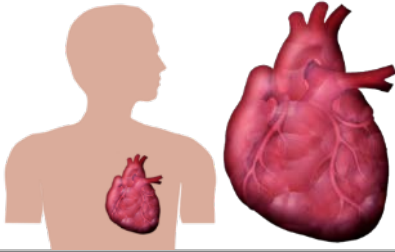
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**your family history**

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

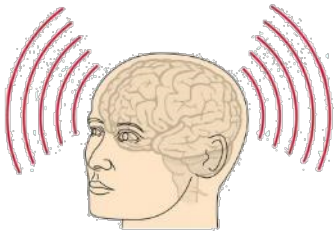
**heart disease (heart attacks, angina)**



yes  no

which family member?.....

**stroke**



yes  no

which family member?.....

**asthma**



yes  no

which family member?.....

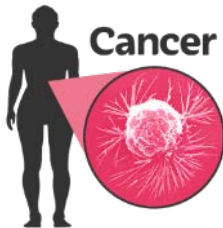
**diabetes**



yes  no

which family member?.....

**cancer**



yes  no

which family member?.....



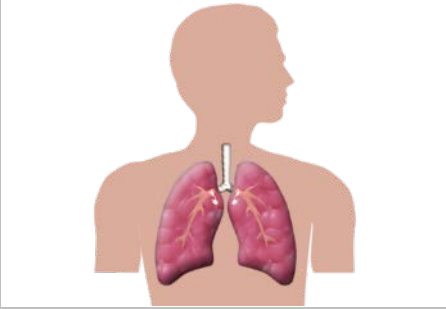
**high blood pressure**



yes  no

which family member?.....

**tuberculosis (TB)**



yes  no

which family member?.....

**other serious illness**



yes  no

which family member?.....

what illness?.....

Thank you for filling in this health questionnaire

- Please book an appointment for a **new patient health check** with the health care assistant (HCA)
- After you have registered, please ask reception to give you patient **online access** details