NORTHGATE SURGERY HEALTH QUESTIONNAIRE FOR NEW PATIENTS

It may be some time before we receive your medical records. In the meantime this questionnaire will give doctors important information about your medical history and will help us to give better service.

Please fill in or circle the appropriate answers.

Today's date: _____

Title: Mr/Mrs/Miss/Ms Other: _____ Place of Birth: _____

First Name: _____ Date of Birth: _____

Family Name: _____ Home Number: _____

Mobile Number: _____ Consent for us to send text messages when you make appointments YES/NO

Email address: _____

Marital Status: Single/Married/Separated/Divorced/Widowed

Have you ever registered with Northgate Surgery before? YES/NO

Previous address including POSTCODE: _____

_____

Previous GP and their address: _____

_____

If you have not lived in Great Britain before please state date you entered the country: _____

If you are returning from the Armed Forces please quote your Service or Personnel Number:

_____

Religion: _____

Name of next of kin: _____ Relationship to you: _____

Next of Kin telephone number: _____

Are you a carer? YES/NO Do you have a carer? YES/NO

Your main spoken LANGUAGE is: _____

PLEASE TURN OVER

Please circle your ethnic background (The Office of National Statistics breakdown list)

White	Mixed
British	White and black Caribbean
Irish	White and black African
Scottish	White and Asian
Any other white background	Any other mixed background

Asian or Asian British	Black or Black British	Other Ethnic Group
Indian	Caribbean	Chinese
Pakistani	African	Any other
Bangladeshi	Any other black background	
Any other Asian background		

If you choose not to state your Ethnic category please leave the above blank and tick here: _____

Have you had any of the following medical problems? Please circle YES/NO as appropriate.

ALLERGIES	YES/NO	Smoking status	YES/NEVER/PAST
Arthritis	YES/NO	Smoking advice given	YES/NO
Asthma	YES/NO	Alcohol consumption units per week	_____
Cancer	YES/NO	Weight	_____
Chronic Bronchitis	YES/NO	Height	_____
Depression/other illness	YES/NO	BP	_____
Diabetes	YES/NO	Family History of:	
Epilepsy	YES/NO	IHD < 60 yrs	YES/NO
Heart attack or angina	YES/NO	IHD > 60 yrs	YES/NO
High blood pressure	YES/NO	CVA/Stroke	YES/NO
Stroke	YES/NO	Diabetes	YES/NO
Thyroid problem	YES/NO	Asthma	YES/NO
Tuberculosis	YES/NO	If yes as above FH which family member	
Ulcer (duodenal or gastric)	YES/NO	_____	
Are you registered disabled	YES/NO		
If yes please state _____			

How often do you exercise? Number of times per week: _____ What type of exercise? _____

Do you have any specific needs? ie; Speech, sight, mobility or hearing impairment YES/NO

If yes please state:

_____

Have you had any other illness, accident or operations in the past? YES/NO
If YES please give details:

Description	Hospital	Year

_____
_____
_____

Are you under the care of a hospital specialist at the moment? YES/NO
If YES please give details:

Name of Specialist Hospital Diagnosis

_____
_____
_____

Are you taking any medications or tablets at the present time? YES/NO
IF YES PLEASE ATTACH THE TEAR OF SLIP FROM YOUR CURRENT PRESCRIPTION

Name of tablet/medicine Dose/strength Time per day

_____
_____
_____

Do you have any ALLERGIES to medicines or tablets? YES/NO
If YES please give details

_____
_____

When did you last have a blood pressure check? _____

When did you last have a tetanus booster injection? _____

FOR WOMEN ONLY

Have you ever been pregnant? YES/NO
If YES how many pregnancies have you had? _____

Have you had any problems connected with pregnancies? (Difficult deliveries, miscarriages etc? YES/NO
If YES please state: _____

When was your last cervical smear? _____

For more information about the services we offer please refer to your patient pack or see our website: northgatesurgery.org

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

For office use only

Signature of NURSE/HEALTH CARE ASSISTANT _____ Date: _____

PLEASE TURN OVER

Alcohol Users Indentification Test (AUDIT) C

How much is too much?

Name: _____ Date of Birth: _____

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	
					TOTAL	