YOU MUST FULLY COMPLETE AND BRING TO RECEPTION TO REGISTER AS A PATIENT AT GUDGEHEATH LANE SURGERY

New Patient Health Questionnaire (Adult)

Name: …………………………………………………………………… **Date of Birth:** ……………………………

Address (including postcode)…………………………………………………………………………………..

Home telephone number: ……………………… ………..**Mobile number:**………………………………………
Are you happy for text messages, for medical reminders and surgery marketing (from the surgery only) to be sent to the mobile number given? **YES / NO**
Are you happy for the surgery to leave a message on an answerphone on the above numbers: **YES / NO**

Email address: …………………………………………………… (We may use this to keep you updated with Services at the Surgery)

Please make us aware of any communication needs you may have so that we can assist you

1. Are you a Veteran of the British Armed Forces or a Merchant Seaman who served in operations by the Armed Forces? **YES / NO** **Army / Navy / Airforce (admin- code 'Military Veteran')**
2. Are you the Spouse/Partner of a Military Veteran? **YES / NO (admin – code ' dependant of former military personnel')**
3. Are you part of a current Armed Forces family **YES / NO**? (**admin - code 'member of military family')**
(i.e spouse/partner/child of currently serving personnel)

Next of Kin Details : Name:………………………… ….. Relationship:….………………………….

Address: ………………………………………………......... Tel: number:……………………………..

Carer's Details: Name:…………………………………… Relationship:….………………………….

Address: ………………………………………………........ Tel number:………………………………

Medical Information - Any allergies? ………………………………
Smoking Status: ❑ Current (how many)? ❑ Ex-smoker (Quit date) ………. …. ❑ Never smoked

Personal Medical History including Major Operations

Details: ..………………………………………… Date ……………………….
Details: ..……………………………………….. Date ……………………….

Have you ever suffered from any of the following conditions:

CONDITION	IF YES, APPROXIMATE DATE	CONDITION	IF YES, APPROXIMATE DATE
Diabetes Type 1 or 2		Peripheral vascular disease	
High Blood pressure		Depression	
Stroke/TIA "mini stroke"		Dementia	
Cancer		Mental Health condition eg. schizophrenia	
Heart Attack/Angina		Osteoporosis	
Atrial Fibrillation		Heart Failure	
History of Asthma/COPD		Epilepsy	
Rheumatoid Arthritis		Other	

Are you taking any regular medication? If yes, please also bring a copy of your repeat slip with you

NAME	DOSAGE
1.	
2.	
3.	

Please Nominate a Pharmacy from where you would like to collect your medication: ………………………………………

Family History

CONDITION	RELATION	AGE AT DIAGNOSIS
Cancer		
Heart disease		
High blood pressure		
Stroke		
Diabetes		
Angina		
Asthma		

Women Only

Do you take a contraceptive pill? **YES / NO** If yes, which one? ……………………………………………………..

Do you have a Coil or Implant fitted? **YES / NO** – If yes, date fitted? ……………………………………………

Date and result of last cervical smear? (if applicable) ……………………………………………………………..

Have you had a hysterectomy or any other gynecological operations? **YES / NO -** If yes, please give details:…………………………………………………………………………..

Alcohol intake: No of units per week? ☐

(Pint of beer or medium glass of wine = 2 A single spirit measure = 1
A score of 5 or more indicates increasing or higher risk drinking

QUESTIONS	SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	YOUR SCORE
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 units or more if female, or 8 units or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Sharing of medical records: Please refer to the Privacy Notices given to you on registering as a patient at the surgery.

We ask that you refer to the information in your registration pack or on our website www.gudgeheathsurgery.co.uk to give your consent to share your medical record in the ways described. *However, you can ask for your information not to be shared outside of the practice.* **Please complete Data Sharing Options form and return this to the surgery** *when you attend for your New Patient Health Check. If you decide to opt out it will not affect your entitlement to care. However, it may result in the delivery of your care being less efficient as clinicians will not see your full medical history. If you have any concerns about how your information is shared or held, please contact the Practice Manager.*

Signed…………………………………………… Date Completed………………………………………………