IG MEDICAL PRACTICE – NEW PATIENT HEALTH QUESTIONNAIRE FOR PATIENTS OVER 16 YEARS OF AGE

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 you a better service – please complete as fully as possible.

PATIENT DETAILS

Title	**Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other:**	**Surname**	
Date of Birth		**First names**	
Occupation		**Previous Surnames**	
Home Address:		**Home Tel**	
		Work Tel	
		Mobile	
Postcode:		**Email** **Do you Require Log-in and Password for On-line access**	

What is your first language?	**Do you speak English?**

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 ID AND ADDRESS WILL BE REQUIRED AND A COPY TAKEN OF ID DETAILS

☐ **Birth Certificate**	☐ **Photo driving Licence**	☐ **Bank or Mortgage a/c**	☐ **Passport**
☐ **Allowance Book**	☐ **Offer of Tenancy**	☐ **Solicitor's Letter**	☐ **Other**

MEDICAL INFORMATION

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place			
Have you ever suffered from? (tick as appropriate)			
Epilepsy	☐ Yes ☐ No	**Blindness/Glaucoma**	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No
Heart Attack/Stroke	☐ Yes ☐ No	**Depression**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Asthma**	☐ Yes ☐ No
Eczema/Hay Fever	☐ Yes ☐ No	**COPD**	☐ Yes ☐ No
Please list any medicines being taken and the amount:			
Are you registered disabled? (If yes, please give details)			☐ Yes ☐ No
Are you allergic to any medicines and if so, which?			☐ Yes ☐ No
Have you ever refused treatment/screening of any kind and if so, what?			☐ Yes ☐ No

OTHER INFORMATION

Carers			
Do you have a carer? (If yes please give details)			☐ Yes ☐ No
Are you a carer? (If yes please give details)			☐ Yes ☐ No
Women 25-60			
When was your most recent cervical smear? **DATE:** ……..			
Please state result if known:			
Smoking			
Do you smoke?			☐ Yes ☐ No
If 'No', have you ever smoked?			☐ Yes ☐ No
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per day?			
Would you like advice on giving up smoking?			☐ Yes ☐ No
Alcohol **1 unit = 1/2 pint of beer or 1½ small glass of wine or 1 single spirits**			
How many units per week?			
MEN: How often do you have EIGHT or more drinks on one occasion? **WOMEN: How often do you have SIX or more drinks on one occasion?**			
How often during the last year have you been unable to remember what happened the night before because you had been drinking?			
How often during the last year have you failed to do what was normally expected of you because of drinking?			
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?			
Height and Weight			
What is your height?		**What is your weight?**	

FAMILY HISTORY

Please state any serious illness, in particular heart attacks/ angina/strokes/high cholesterol (any of these only under the age of 55 years); cancer; high blood pressure; diabetes; or any inherited disease; and which family member was/is affected

FOR PATIENTS AGED 65 AND OVER

Please give name, address, telephone number and relationship of next of kin

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'	

Signature	Date

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you.

THE INFORMATION GIVEN IS IN STRICTEST CONFIDENCE AND ONLY USED BY YOUR HEALTH PROFESSIONAL