

The Cannon Hill Lane Medical Practice

New Patient Health Questionnaire

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help at your health check and with your future treatment.

Surname: Forename(s):

Date of Birth: Marital status:

Address:

..... Postcode:

Home tel: Mobile:

Email address:

Occupation:

Weight (approx): Height:

Ethnicity: Main spoken language.....

Date of completion of this form:

SMOKING

Do you smoke? Yes / No

If Yes, how many:

Cigarettes per day Cigars per day Ounces of tobacco per day

How old were you when you started smoking?

EX-SMOKERS

How old were you when you stopped smoking?

How much did you smoke per day?

ALCOHOL

Question	Score 0	Score 1	Score 2	Score 3	Score 4	Your score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a 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	

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?

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: Name of drug:
 Dosage: Dosage:

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:

.....

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

.....

Please give details of any treatment for any chronic medical conditions:

.....

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

.....

IMMUNISATIONS

Dates of Triple/polio/HIB:

Dates of MMR:

Date of last Tetanus:

FEMALE PATIENTS

Date of most recent cervical smear:

Result of most recent smear:

Where was most recent smear taken:.....

Please give details of any complications in pregnancy:

.....

CARERS

Do you need / 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

When you attend for your health check please can you bring a urine sample with you. Sample bottles are available at reception.

Thank you for completing this questionnaire.