New Patient Health Assessment Questionnaire (age 5 and over)

If you are asked to attend a New Patient Health Assessment please bring a sample of urine with you (bottles are available at Reception)

Name:		**Date of Birth:**	
Address:		**Telephone (home):** **Mobile:**	

Please indicate (tick) if you are happy for us to use your mobile to send SMS messages ☐

Marital Status:			
Next of Kin (NOK):		**Relationship:**	
Telephone:		**Signed by NOK:**	

1. Current, Past Illnesses and Operations **Date** **Hospital Attended**

a) _____
b) _____
c) _____
d) _____
e) _____
f) _____

2. Tetanus Immunisation Date of last injection (if known) _____

3. Are there any diseases e.g. heart disease, stroke, diabetes, asthma, glaucoma, cancers, osteoporosis, to which your family is prone?

Yes / No (if yes give details)

4. Are you taking any regular prescribed medication? Yes / No (if yes give details)

	Drug	*Strength*	*Dose*	*Times per Day*
a)				
b)				
c)				
d)				
e)				

5. Do you buy medicines over the country from the chemist? Yes / No (if yes give details)

	Drug	*Strength*	*Dose*	*Times per Day*
a)				
b)				
c)				
d)				
e)				

6. Do you have any allergies? Yes / No (if yes give details)

a)	
b)	
c)	

7. Have you had any of the following tests/checks?

a) Cervical Smears (last date and results) _____
b) Mammography (last date and results) _____

8. Are you in paid employment, education, or retired, or unable to work? (give details)

9. What is your residential status? Own home / Rented Home / Homeless at present

10. How many people live with you? _____

11. Does the space or condition or your home cause any problems? Yes / No

12. Do you have communication difficulties of any kind (e.g. language, vision, hearing) Yes / No

13. Do you have children? Yes / No Are you a single parent? Yes / No

Childrens Name(s)	Date of Birth

14. Are you a carer? Yes / No (if yes give details)

For (name)	Relationship	Date of Birth

15. Are you cared for? Yes / No (if yes give details)

For (name)	Relationship	Date of Birth

16. How would you describe your diet?

17. What exercise do you get?

18. Do you smoke? Yes / No

a) If yes, how many per day? _____ Date started _____
b) Are you an ex-smoked? Yes / No Date Stopped _____

19. How much alcohol do you drink per week (units) _____

20. Have you ever misused drugs or solvents? Yes / No

For Doctor / Nurse / HCA Use Only

Initials | Date

Height (cms) | Weight (kgs) | Blood Pressure /

Smoking advice given Yes / No | Urinalysis

Comments: