



SWANWOOD PARTNERSHIP

Applewood Surgery, Wickford Health Centre
Market Avenue, Wickford, SS12 0AG Tel: 01268 562444

New Patient Health Questionnaire

(Please complete the form and hand it in at the reception along with the completed GMS1 form and any other required documents)

Patient Details

Title	Mr	Mrs	Miss	Ms	Surname	
Date of Birth	Age		First Names			
Occupation	Previous Surnames					
Home Address:						
Post Code:						
Tel No:		Mobile:		Work:		
E-mail address:						
Name and Address of Previous GP:						

Ethnic Group

<input type="checkbox"/> White	British	<input type="checkbox"/> Black	Caribbean
	Irish		African
	Other (Please specify)		Other (Please specify)
<input type="checkbox"/> Asian	Indian	<input type="checkbox"/> Mixed	White & Black Caribbean
	Pakistani		White & Black African
	Chinese		White & Asian
	Other (Please specify)		Other (Please specify)
Other ethnic group (please specify):			

Language

What is your first language?

Proof of Identity (required)

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Driving Licence	<input type="checkbox"/> Passport	<input type="checkbox"/> Utility Bill
<input type="checkbox"/> Allowance Book	<input type="checkbox"/> Solicitor's Letter	<input type="checkbox"/> Offer of Tenancy	<input type="checkbox"/> Other
*For staff use only: please tick the type of ID provided and put your initial			
*Patient Resides in Practice Area: (Mandatory for staff to check and initial the box)			

Your height:

Your weight:

Do you smoke?	Yes	No	Did you know? Smoking is the UK's single greatest cause of preventable illness
If no, have you ever smoked?	Yes	No	

If yes how many cigarettes or ounces of tobacco per week?

Would you like advice on giving up smoking?	*Yes	No	*If yes please discuss with nurse
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Alcohol History	<input type="text"/>	units
How much alcohol do you drink in a week?		
(1 unit = ½ pint beer, 1 small glass of wine, 1 single spirit, 1 small glass of sherry or 1 single aperitif)		

Medical Information

Have you ever suffered from? (tick as appropriate)				Any family history of these			
Your self				Family History		If yes, who in family?	
Epilepsy	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High Blood Pressure	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Attack/Stroke	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Blindness/Glaucoma	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Thyroid Disorder	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Depression	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chronic Lung Disease	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Eczema/Hay Fever	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Deep Vein Thrombosis	Yes	<input type="checkbox"/>	No	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other conditions							

Please list any serious illnesses/operations/accidents/disabilities (and for women, pregnancy related problems) and the year they took place.

Are you up to date with all your immunisations?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Date of your last Tetanus Immunisation if known:				

Medications:

Are you currently taking any repeat medications	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes: please list all prescribed medications being taken and the dosages

*Please note that, you may have to make an appointment with the doctor to set up your repeats.
At times it may be possible to set repeats if you submit your medication list from the previous GP.

Allergy

Are you allergic to any medicines and if so, which?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any food / nuts or other allergies?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Have you ever refused treatment/screening of any kind, and if so what?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Give details:
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Are you registered disabled?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes please give details of your disability:

Women

Have you ever had a cervical smear?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date of last smear:
Any family history of breast cancer?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes state relation:
Have you had a mammogram?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	State date:
Migraine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If you suffer from migraine and taking a combined contraception pill: see the doctor
Have you had rubella immunisation?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Any pregnancy related complications	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	

OVER 16's ONLY

Alcohol Users Disorders Identification Test (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-3 times per month	2-3 times per week	4+ per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

For Patients aged 65 and over

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

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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 a date or 'never'	

Other information

Do you have a carer?	Yes		No	
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If yes please give details of your carer:

Are you a carer?	Yes		No	
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If yes please give details of who you care for:

Do you hold a living will?	Yes		No	
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(Documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

*Do you Consent for Appointment's & Messages to be sent by SMS?	Yes		No	
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*Do you Consent to record sharing?	Yes		No	
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Surgery Website: For more information on our practice catchment boundary, practice policies, services provided, visit our websites www.swanwood.com

Patent Declaration:

*I have checked and confirm that I live with in the Swanwood Partnership Practice Boundary Area I confirm the information provided on this form is correct and agree to the Practice terms on information sharing (a copy of the practice confidentiality and information sharing policy is available at reception and also on our website.

Signature:

Date:

Please note: You will be offered a **New Patient Check** appointment with the nurse

- **When attending new patient check appointment:**
 - **Please bring in a urine specimen in a white top bottle which is available from the reception.**
 - **Bring in your repeat medication slip from previous GP in order for us to issue you these.**