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

White		British	Black		Caribbean
		Irish			African
		Other (Please specify)			Other (Please specify)
Asian		Indian	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)

	Birth Certificate		Driving Licence		Passport		Utility Bill
	Allowance Book		Solicitor's Letter		Offer of Tenancy		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

Alcohol History How much alcohol do you drink in a week?		units
(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		No			Yes		No		
High Blood Pressure	Yes		No			Yes		No		
Heart Attack/Stroke	Yes		No			Yes		No		
Cancer	Yes		No			Yes		No		
Diabetes	Yes		No			Yes		No		
Blindness/Glaucoma	Yes		No			Yes		No		
Thyroid Disorder	Yes		No			Yes		No		
Depression	Yes		No			Yes		No		
Asthma	Yes		No			Yes		No		
Chronic Lung Disease	Yes		No			Yes		No		
Eczema/Hay Fever	Yes		No			Yes		No		
Deep Vein Thrombosis	Yes		No			Yes		No		
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		No		
Date of your last **Tetanus Immunisation** if known:					

Medications:

Are you currently takings any repeat medications	Yes		No	

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		No		
Do you have any food / nuts or other allergies?	Yes		No		

Have you ever refused treatment/screening of any kind, and if so what?	Yes		No		Give details:

Are you registered disabled?	Yes		No	

If yes please give details of your disability: ……

Women

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

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:

……

……

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	

If yes please give details of your carer: ……..……..

……

Are you a carer?	Yes		No	

If yes please give details of who you care for: ……..

Do you hold a living will?	Yes		No	

(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	

***Do you Consent to record sharing?**	Yes		No	

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.*