

**Beaconsfield Surgery New Patient Health Questionnaire**

**Date:** ..... **Title:** Mr Mrs Miss Ms Other

**Surname** ..... **Forename** .....

**Date of Birth** ..... **Sex:** M/F **Ethnicity:** .....  
(As some ethnic communities are susceptible to certain disease)

**First Language Spoken**.....

**Marital Status:** ..... **Occupation** .....

**Address:** .....

..... **Post Code** .....

 **Tel No: Home** .....  **Work** .....  **Mobile**.....

**I consent to the practice contacting me by text/sms messaging on the mobile number above** Yes [ ] No [ ]

**I consent to the practice contacting me by e.mail on the following e.mail address**  
..... Yes [ ] No [ ]

**Previous Doctor** .....

**Are you the main carer for anyone in your household (please state)** Yes [ ] No [ ]

**Next of Kin: Name**.....

**Address:** .....

..... **Tel:** .....

**Is your Next of Kin registered at this surgery** Yes [ ] No [ ]

**Relationship to next of kin**.....

**Please confirm if you are happy for the GP to discuss medical issues with your named next of kin.**

**Yes I consent to the GP discussing medical issues with my named next of kin**

**Signature**.....

**Beaconsfield Surgery New Patient Health Questionnaire**

**Yes I consent to my GP creating a Summary Care Record for me and uploading it to the National Electronic Database.**

**Signature.....**

**No I do not consent to my GP creating a Summary Care Record for me and uploading it to the National Electronic Database**

**Signature.....**

**PAST MEDICAL HISTORY:**

Please list any illness you have

**HOSPITAL ADMISSIONS:**

Please list and include dates of any operations if possible

**DO YOU SUFFER FROM ANY OF THE FOLLOWING:**

High blood pressures	Yes [ ] No [ ]	Diabetes	Yes [ ] No [ ]
Heart disease	Yes [ ] No [ ]	Epilepsy	Yes [ ] No [ ]
Asthma	Yes [ ] No [ ]	Migraine	Yes [ ] No [ ]
Mental illness of any type	Yes [ ] No [ ]	Kidney problems	Yes [ ] No [ ]
Hearing problems	Yes [ ] No [ ]	Bowel problems	Yes [ ] No [ ]
Sight problems	Yes [ ] No [ ]	Urinary problems	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Indigestion	Yes [ ] No [ ]
Blood problems	Yes [ ] No [ ]	Cancer	Yes [ ] No [ ]
Thyroid problems	Yes [ ] No [ ]	Stroke/TIA	Yes [ ] No [ ]

Please provide details you feel are relevant to the above

Please indicate if you have a family history of stroke or heart disease:

Mother or sister (before age 65) Yes ( ) No ( )

Father or brother (before age 55) Yes ( ) No ( )

If Yes please give further details.

## **Beaconsfield Surgery New Patient Health Questionnaire**

Do you take any medications? Include the name, dose and frequency that you take them – or attach your repeat prescription request sheet. Please state which medicine you purchase from the chemist.

Do you have any allergies (please state) Yes [ ] No [ ]



**HEIGHT:**.....



**WEIGHT:**.....



**SMOKING:**

Have you **ever** smoked cigarettes or tobacco? Yes [ ] No [ ]

Are you a smoker now? Yes [ ] No [ ] how many?

If you are an ex smoker when did you give up?

Would you like advice on how to give up? Yes [ ] No [ ]



**DRINKING**

Do you drink alcohol? Yes [ ] No [ ]

How much do you drink each day?  
(1 unit = ½ pint of beer, 1 single spirit, 1 glass of wine)

How often do you drink Six units (if you are female) or Eight units (if you are male) on one occasion?



**EXERCISE**

Do you take 30 minutes a day of at least moderate exercise more than 5 times per week?

Do you take less than 30 minutes a day of physical exercise 5 times a week?

What type of exercise?

## Beaconsfield Surgery New Patient Health Questionnaire



Do you have a special diet? (please state)

Intake of fruit and vegetables less than 5 portions daily?

Intake of fruit and vegetables at least 5 portions daily?



### **IMMUNISATIONS:**

Please tick box if yes and provide if possible

Tetanus	<input type="checkbox"/>	.....	Flu	<input type="checkbox"/>	.....	Typhoid	<input type="checkbox"/>	.....
Polio	<input type="checkbox"/>	.....	Hepatitis A	<input type="checkbox"/>	.....	Yellow Fever	<input type="checkbox"/>	.....
MMR	<input type="checkbox"/>	.....	Hepatitis B	<input type="checkbox"/>	.....	Pertussis	<input type="checkbox"/>	.....
Rubella	<input type="checkbox"/>	.....	BCG	<input type="checkbox"/>	.....	(whooping cough)		
Diphtheria	<input type="checkbox"/>	.....	Meningitis	<input type="checkbox"/>	.....			

Please give name, relationship and date of birth of any family members who live with you and are registered at this practice.



**We encourage all patients to attend a New Patient Health Check appointment which can be made with reception. This 20 minute appointment includes blood pressure, BMI, lifestyle counselling, routine urine testing and cholesterol check if felt necessary. We also offer Chlamydia screening for under 25s.**

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**Beaconsfield Surgery New Patient Health Questionnaire**

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**THIS SECTION TO BE FILLED IN FOR/BY UNDER 16's ONLY**

**Name of Parent/Guardian** .....

**School** .....

Do you provide regular care to anyone in your household, a family member, friend or neighbour? (please state) Yes [ ] No [ ]

Do you consider you have any problems with housing? Yes ( ) No ( )

**At this surgery we have a policy that all young people between the age of 5 and 16 years attend for this health check. Please book an appointment.**

**You will receive a password and username to access our online services, this allows appointment booking, repeat prescription requests and changes to your personal details. If you do not receive this within two weeks please contact reception.**

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**FOR COMPLETION BY PRACTICE NURSE**

Height:

Weight:

Blood Pressure:

Urinalysis