BEAUCHAMP HOUSE SURGERY

NEW PATIENT HEALTH QUESTIONNAIRE

Tel: 01245 262255

Title		**Surname**	
Date of Birth		**First name(s)**	
Place of Birth		**Previous Surnames**	
Occupation		**Marital Status**	
Home Address		**Home tel**	
		Mobile No	
Post Code		**If you DO NOT want to receive text message reminders from the surgery for booked appointments please tick the box** ☐	
Next of kin: Name		**Next of kin: Relationship**	
Next of kin: Contact details			

Communication

Do you have any special communication requirements? If yes, please give details

Ethnic Group (Please circle applicable group and specify if other)

White	British	Irish	Other	
Black	Caribbean	African	Other	
Asian	Indian	Pakistani	Chinese	Other
Mixed	White + Black Caribbean White + Asian		White + Black African Other	

Previous Medical History (Have you ever suffered from any the following? – tick as appropriate)

Asthma ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
COPD ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Eczema/Hayfever ☐ Yes ☐ No
Heart attack/Angina ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Other medical conditions

Any Operations (Approximate dates)

Do you have any allergies? ☐ Yes ☐ No Please specify

Please give details of any regular medication (*Prescribed or over the counter*) if applicable

Please give details of any ongoing hospital care (Specialty, which hospital etc)

How would you describe your level of exercise? ☐ Inactive ☐ Gentle ☐ Moderate ☐ Vigorous

Do you have a carer (If yes please give details) ☐ Yes ☐ No Details

Are you a carer (If yes please give details) ☐ Yes ☐ No Details

Please continue overleaf

Family History – Has either one of your parents or anyone of your siblings ever been diagnosed with any of the following?

Heart attack ☐ Yes ☐ No Stroke ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Asthma ☐ Yes ☐ No
Breast Cancer ☐ Yes ☐ No Bowel Cancer ☐ Yes ☐ No Other Diseases

Recent Immunisations

Type of immunisation	Date

For Women Only

What type of contraception do you use?

☐ None ☐ Pill ☐ Implant ☐ Patch ☐ Coil ☐ Injection

Date of insertion of implant Date of last injection

Type of coil: IUS (mirena) IUD (copper) Date inserted

Have you ever had a smear? ☐ Yes ☐ No Date of last smear

Do you smoke? ☐ Yes ☐ No If yes, what do you smoke?

Are you an ex-smoker? ☐ Yes ☐ No

Alcohol Use Disorder Identification Test – Consumption (AUDIT-C)

Remember, drinks poured at home are usually bigger

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total→	

Signature ***Date***

******Please bring a urine sample and a copy of your repeat medication slip to your new patient check ******