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**<br><br>**Post Code** | | **Home Telephone** | |
| | | **Mobile Telephone** | |
| | | **Email** | |
| | | **Main spoken language** | |
| | | **Nominated pharmacy** | |
| | | **If you WOULD LIKE to receive text messages from the surgery for booked appointments, invites and health promotions please tick the box** ☐ | |
| **Next of kin: Name** | | **Next of kin: Relationship** | |
| **Next of kin: Address and Tel** | | | |

| | |
|---|---|
| **Gender (please circle)** | Male (including trans men) / Woman (including trans woman) / Non-binary / In another way (please specify) |
| **Is this the gender you were assigned at birth?** | Yes / No |
| **Sexual Orientation (please circle)** | Lesbian or Gay / Straight or Heterosexual / Bisexual / Other (please specify) |

**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<br>White + Asian | | White + Black African<br>Other | |

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

Asthma ☐ Yes ☐ No  High Blood Pressure ☐ Yes ☐ No  Heart attack/Angina ☐ Yes ☐ No

Stroke ☐ Yes ☐ No  Diabetes ☐ Yes ☐ No  Epilepsy ☐ Yes ☐ No

COPD ☐ Yes ☐ No  Eczema/Hayfever ☐ Yes ☐ No  Depression ☐ Yes ☐ No

Other medical conditions

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

**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, Trans Men and Non-Binary People with a cervix (or other people with a cervix)

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 ******