MID DEVON MEDICAL PRACTICE - New Patient Health Questionnaire - Adult

This is a private form and all information will be treated confidentially

Please note: It is your responsibility to advise the Surgery of any changes to your contact details

Contact details

Title:	Surname:	Forename:
Address:		
Date of Birth: / /	NHS No (if known)	Home telephone No:
Email:	Mobile No:	Consent to leave voice messages on home / mobile tel? **Y** ☐ **N** ☐

By giving us your mobile telephone number/email address you are consenting for us to be able to contact you via text message/email.

Marital Status: Single / Married / Cohabiting / Civil Partnership / Separated / Divorced / Widowed / Other

Next of Kin

Name:	Relationship:
Contact details (tel):	
At same address? Y/N Address if different:	

Ethnic Origin (please circle one)

[White British] [White, other] [Indian] [Pakistani] [Chinese] [Bangladeshi] [Other] [Asian ethnic group]
[Black Caribbean] [Black African] [Black other non-mixed origin] [Black other mixed origin] [Other black ethnic] [Other ethnic non-mixed] [other ethnic mixed origin]
Other……. Do not wish to answer

Is English your first language?	Yes	No
If English is not your first language what is?		
Will you need an interpreter to help you with medical appointments?	Yes	No

Main Occupation

Allergies

Family history – do you have any family members who have, or have had a serious illness? YES/NO
If yes, please tick as appropriate and state age when the condition started

	Father	Age	Mother	Age	Brother	Age	Sister	Age
Diabetes								
High Blood pressure								
Heart attack								
Stroke								
Asthma								
Cancer								

Previous illnesses/medical conditions (excluding minor problems unless they are recurrent)

Year	Illness

Have you had any operations?

Year	Operation

Are you awaiting any medical treatment?

Treatment	Where	When

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Immunisations

Vaccination	Date	Vaccination	Date
Tetanus		Rubella	
Diphtheria		MR/MMR	
Polio		Hep B	
BCG		Other:	

Current Medical Status Height…….. Weight…….. BP ……Sys…….Dia

Method of Contraception (If applicable)……..

Women Only

Have you ever had a smear test? Yes No Date……
Are you taking the pill? Yes No Which one?.....
Are you fitted with an IUCD (coil or loop)? Yes No Type?.....
Have you had a hysterectomy? Yes No

Births

Date	Complications	Problems of delivery	Birth weight

Alcohol

Questions	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times a month	2 -3 times a week	4+ times a week	
How many standard alcohol drinks do you have on a typical day when 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	

Activity

How often do you take moderate to vigorous exercise for at least 20 minutes?				
Exercise physically impossible	No regular exercise	Once per week	Twice per week	Three or more times per week

Moderate to vigorous exercise is activity that makes you sweat or raise your pulse such as swimming, cycling, brisk walking.

Smoking Status

Which of the following best describes you?		
Never Smoked	Ex-Smoker. Date Stopped……	Current Smoker. Amount per day……

If you would like help to stop smoking please ask for information on NHS support to quit. Contact the national NHS stop smoking helpline on 0300 123 1044 or ask at Reception about our Smoking Cessation Clinic.

Medication

Do you take any regular medication?	Yes	No

If **yes**, please attach a repeat prescription list. When you need more of your repeat medication, you do not need to see your Doctor, please contact your Doctors secretary.

Repeat prescriptions are processed within 48 hours. Please allow 72 hours before collecting medications.

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Carer

Do you look after someone who is ill, frail, disabled or mentally ill?	Yes	No
Does someone look after you?	Yes	No

If the answer to either question above is yes please ask about our Carer Health Checks and other support services.

Other Support

Do you use anything to help with your mobility, hearing or speaking?	Yes	No

If yes, please tick any of the list below which you use:

Wheelchair	Walking aid	Hearing aid	An advocate	Hearing loop	Text phone
Other (please state)					

Do you require communications in an alternative format?	Yes	No

If yes, please tick any of the list below which you require.

Audio tape	Braille	Large print	Other (please state):

Although we will do our best to supply information in the requested format this may not always be possible.

Sharing your medical record

Summary Care Record contains details of a small but important part of your GP medical records - medications, allergies and adverse reactions. They are accessible to authorised health care staff in A&E Departments throughout England. You should always be asked your permission before anybody looks at your Summary Care Record. More information is available at:
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/servicedescription.aspx

Do you want to have a Summary Care Record?	Yes	No
Do you want to have a Local Shared Care Record?	Yes	No
Do you wish to register for Online Patient Access which will enable you to make appointments and to order your prescriptions online. Please ensure we have your correct email address to enable us to activate your account and to forward your login details.	Yes	No

Signed …… Today`s Date……

Please return this form together with your completed GMS1 REGISTRATION FORM, PHOTO ID and PROOF OF ADDRESS/UTILITY BILL.

For office use only	
Proof of residency / ID checked	
☐ Passport	☐ Birth Certificates
☐ Driving Licence	☐ Proof of Address / Utility Bill
☐ Work / Study Permit	Signature of member of staff: