NEW PATIENT HEALTH QUESTIONNAIRE

Your Contact Details

Title		Date of Birth	
Surname		Forename(s)	
Previous Surnames		Email	
Home Address	House Name / Flat		
	No and Street		
	Village		
	Town		
	Postcode		
Home Tel		Work Tel	
Mobile		Other Tel	
Occupation			

Are you a Military Veteran? If you have served in UK Armed Forces, please indicate which service. (For Reservists/Territorial Army please confirm if you have served as Regular service personnel for more than one day e.g. deployed on Operations (OP HERRICK etc), please also indicate which service deployed with)	O Royal Navy O British Army O Royal Air Force O Reservist / Territorial Army

Information about you

What is your height?		What is your weight?	
What is your first language?			

Ethnic Group

White	O British	O Irish	O Other	If other please specify	
Black	O Caribbean	O African	O Other	If other please specify	
Asian	O Indian	O Pakistani	O Chinese	O Other	If other please specify
Mixed	O White + Black Caribbean		O White + Black African		O White + Asian
	O Other		If other please specify		

Previous GP

GP Name	
Surgery Name	
Surgery Address	
Postcode	

Medical Information

Please list any serious illnesses / operations / accidents / disabilities (and for women any pregnancy related problems) and the year they took place			
Epilepsy	O Yes O No	Blindness/Glaucoma	O Yes O No
High Blood Pressure	O Yes O No	Diabetes	O Yes O No
Heart Attack / Stroke	O Yes O No	Depression	O Yes O No
Cancer	O Yes O No	Asthma	O Yes O No
Eczema / Hayfever	O Yes O No	COPD	O Yes O No
Please list any medicines being taken and the amount:			
Are you registered disabled? (If yes, please give details)			O Yes O No
Are you allergic to any medicines and if so, which?			O Yes O No
Have you ever refused treatment/screening of any kind and if so, what?			O Yes O No
Have you ever suffered from? (tick as appropriate)			
Anxiety	O Yes O No	Depression	O Yes O No
OCD	O Yes O No	Bipolar Disorder	O Yes O No
Do you have any other mental health issues? If yes please give details			O Yes O No
Are you receiving or have you received any treatment or therapy? (If yes please give details)			O Yes O No

Women

Have you ever had a cervical Smear?	O Yes O No
If yes, please give the date of your last smear	

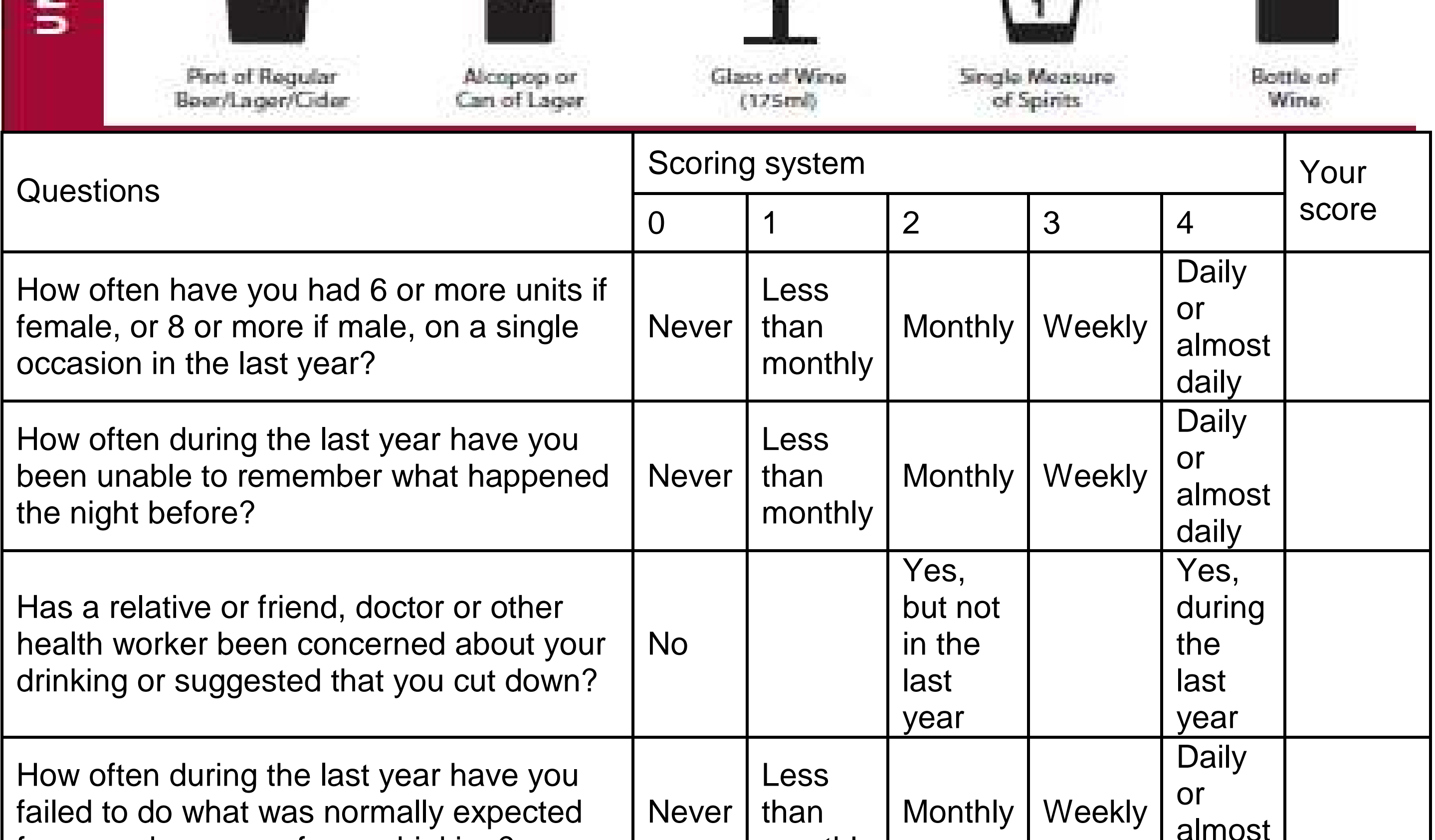
Carer

Do you have a carer? (If yes, please complete attached form)	O Yes O No
Are you a carer? (If yes, please complete attached form)	O Yes O No

Smoking

Do you smoke?	O Yes O No
If 'No', have you ever smoked?	O Yes O No
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?	
Would you like advice on giving up smoking?	O Yes O No

Alcohol



Questions	Scoring system					Your score
	0	1	2	3	4	
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	
How often during the last year have you been unable to remember what happened the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

A total of 3+ may indicate hazardous or harmful drinking

If you score 3 or more, please fill in the more detailed questionnaire at the end of this questionnaire

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination?	O Yes O No	If Yes enter Date	
Have you had a pneumococcal vaccination?	O Yes O No	If Yes enter Date	

Will

Do you hold a Living Will? O Yes O No (A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

Next of Kin

Please give name, address and telephone number of next of kin

Signature	**Date**

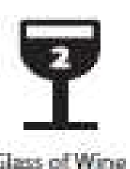
Proof of Identity and Address Provided

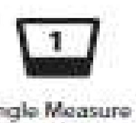
O Birth Certificate O Driving Licence O Passport O Utility Bill O Allowance Book

O Solicitor's Letter O Offer of Tenancy O Other

If other please specify

UNITS





Alcohol Users Disorders Identification Test (AUDIT)

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 – 4 times per month	2 – 3 times per week	4 + times 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	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning or to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes during the last year	
Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = Sensible Drinking, 8-15 = hazardous drinking, 16-19 harmful drinking and 20+ = possible dependence

CARERS IDENTIFICATION AND REFERRAL FORM

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?

If so, you are a carer and we would like to support you. Please complete this form and hand it in to reception.

If you are agreeable, we will pass your details to the Carers Service, which is a countywide organisation providing relevant information and advice, local support services, newsletter and telephone linkline for carers.

We will also refer you, with your permission, to have your needs assessed by Adult Care Services. A Carers Assessment is a chance to talk about your needs as a carer and the possible ways help could be given. It can also look at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

YOUR DETAILS:

Name	
Date Of Birth	
Address Post Code	
Telephone Number	
Any relevant Information	

DETAILS OF THE PERSON YOU LOOK AFTER:

Name	
Date Of Birth	
Address (If Different From Above) Post Code	
Telephone Number (If Different From Above)	
GP Details (If Different From Your Own)	

☐ Please pass my details to the Carers Support Centre.

☐ Please refer me to Adult Social Care Services.

For internal use only - Please pass to Admin Team for Action

For Usual GP - Reviewed to confirm that patient is competent to give a valid informed consent	**YES**	**NO**	**Inits**	**Date**
Computer record updated (Tick code used and enter Sig /Active)	**Carer – 918A**	**Has a Carer – 918F**	**Inits**	**Date**

CONSENT FOR A CARER TO HAVE ACCESS TO A PATIENT'S PERSONAL DETAILS AND/OR COPIES OF CORRESPONDENCE

Patient's Name	
Patient's Address	

To: **Bedminster Family Practice**

I give permission for my Carer ………………………………………………………….
to have access to my medical records and personal details held by the Practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

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I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

I consent to my Carer receiving copies of all correspondence relating to my treatment (*delete if not applicable*). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed _________________________________ (Patient)

Date ___________________________________

Accepted by _____________________________ (Doctor)

Date ___________________________________

Office Use Only:	Date	Actioned (Tick)	Initials
Major Alert entered on EMIS			
Copy Scanned to DOCMAN			
Original Document filed in Lloyd George Notes			