KINGS ROAD SURGERY

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[**www.kingsroadmumbles.wales.nhs.uk**](http://www.kingsroadmumbles.wales.nhs.uk)

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**New Patient Health Questionnaire - Adult**

The questions below have been designed to help your new General Practitioner get to know you and your medical problems.

The information you provide will be handled confidentially by your doctor but if you are concerned about any of the questions, please leave them blank.

|  |  |
| --- | --- |
| **Title:** | **Date of Birth:** |
| **Full Name:** | |
| **Address:** | |
| **Postcode:** | **Home Telephone:** |
| **Mobile Telephone:** | **Work Telephone:** |
| **Email Address:** |  |
| **Nationality:** | **Marital Status:** |
| **1st Language:** |  |
| **Next of Kin Details**  **Name:** | **Next of Kin Address:** |
| **Next of Kin Telephone:** | **Relationship to you (e.g. parent / sibling / partner):** |

**Data Protection**

We may use your mobile number and/or email address to send you appointment reminders and/or invitations to attend vaccination clinics such as Seasonal Flu Clinics and/or invitations to participate in *appropriate* research studies. We will NEVER use your data for non-health related matters.

Please state if there is anything that you **do not** wish to be contacted about:

|  |  |
| --- | --- |
| Height: | Weight: |
| Blood Pressure: | Urine: |
| Pulse: Regular / Irregular | O/E Pulse Rate \_\_\_\_\_\_ Per Minute |

**Carers**

Are you a carer? i.e. looking after a friend or relative? ……………………………………… **Yes/No**

In order that your GP can do all that he/she can do to help, it is important that he/she is aware of your status as a carer.

If you answered “YES”, please ask the receptionist for “Carer Forms”

**Lifestyle**

**Exercise:**

Which of the following applies to you? Please tick one box:

|  |  |
| --- | --- |
|  | I take 30 minutes of aerobic exercise (e.g. cycling, swimming, running) at least 5 times per week |
|  | I walk briskly for 30mins at least 5 times per week |
|  | Other exercise – please state type, duration and frequency: |

**Smoking**

Which of the following applies to you? Please tick one box:

|  |  |
| --- | --- |
|  | I have never smoked |
|  | I used to smoke ………. per day but gave up in (year) ……… |
|  | I currently smoke ………. cigarettes per day |
|  | I smoke cigars or pipe only |

**Diet**

|  |
| --- |
| Please state what diet you have: |

**Women Only**

|  |  |
| --- | --- |
| Women aged 25 to 64 years  Do you wish to have smear testing? | YES / NO |
| Date Last Recorded Cervical Smear: | Result: |
| Contraception: | Rubella Status: |

**Men Only**

Please state:

|  |
| --- |
| Night urine frequency: |
| Stream and flow: |

**The Alcohol Use Disorders Identification Test: Self-Report Version**

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

**Circle the answer that best describes your answer to each question.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Score** |
| 1. How often do you drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |  |
| 2. How many drinks containing alcohol do you have a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |  |
| 3. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 8. How often during the last year have been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 9. Have you or someone else been injured because of your drinking? | No |  | Yes but not in the last year |  | Yes during the last year |  |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No |  | Yes but not in the last year |  | Yes during the last year |  |
|  |  |  |  |  | **Total** |  |

**Family History**

**Do you, or any of your immediate family (parents, grandparents, brothers, sisters, uncles, aunts – please state which relative and the age at which the illness started) suffer from:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Disease | YES/NO | Relative +  age at onset | Disease | YES/NO | Relative +  age at onset |
| High blood  pressure | YES/NO |  | Heart attack | YES/NO |  |
| Diabetes | YES/NO |  | Stroke | YES/NO |  |
| Angina | YES/NO |  | Epilepsy | YES/NO |  |
| Cancer- please  state type  ------------------------- | YES/NO |  | High cholesterol | YES/NO |  |

**What is your Occupation?**

|  |
| --- |
|  |

**Are you a Veteran? Yes / No (delete as appropriate)**

What is a Veteran?

* All Army, Navy and Air Forces personnel who served at least one day are considered veterans for this purpose.
* Reservists
* Former members of the Merchant Navy who took a direct part in legally-defined UK military operations

**Do you have any allergies?**

|  |
| --- |
| Please give details or state “None” |

**Past Health – Illnesses, Accidents or Operations**

|  |
| --- |
| Please list all SERIOUS ILLNESSES, ACCIDENTS, HOSPITAL ADMISSIONS OR OPERATIONS with dates and details of hospital below: |

**Present Health**

|  |
| --- |
| Please state any ongoing condition(s) including any disability that you suffer from: |

**Current Medication**

|  |
| --- |
| Please list present medications: |

**Do you have a Pacemaker fitted?**

|  |
| --- |
| **Yes / No (please delete as appropriate)** |

**Is there any other information that you think your Doctor might need to know (please include detail of any sensory impairment e.g. speech, hearing or visual)?**

|  |
| --- |
| Please give details: |

**As far as you are aware, are you up to date with your routine childhood immunisations?**

|  |
| --- |
| **Yes / No (please delete as appropriate)**  If No please list vaccines that you have **NOT** had; |

**Please See Continuation Sheet**

**Patient Ethnic Origin Questionnaire**

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

**Name…………………………………………. Date of Birth………………………………….**

A White

|  |  |
| --- | --- |
|  | British |
|  | Irish |
|  | Any other white background please write in below |

|  |
| --- |
|  |

B Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background please write below |

|  |
| --- |
|  |

C Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background please write below |

|  |
| --- |
|  |

D Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | White and Asian |
|  | Any other black background please write below |

|  |
| --- |
|  |

E Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other please write below |

|  |
| --- |
|  |