**New Patient Health Questionnaire for Adults**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnic Group**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| White | ⃝ British | ⃝ Irish  | ⃝ Other | If other please specify……………………….. |
| Black | ⃝ Caribbean | ⃝ African | ⃝ Other | If other please specify……………………….. |
| Asian | ⃝ Indian | ⃝ Pakistan | ⃝ Chinese | ⃝ Other | If other please specify……………………….. |
| Mixed | ⃝ White + Black Caribbean | ⃝ White + Black African |   |
|  | ⃝ White + Asian | ⃝ Other | If other please specify……………………….. |

**Main Spoken Language** ……………………………………………………………………………………………………………………………………………

**Do you need an interpreter** ⃝ Yes ⃝ No

**Religion** ………………………………………………………………………………………………………………… ⃝ Prefer not to say

**Marital Status**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ⃝ Single | ⃝ Married | ⃝ Civil Partnership | ⃝ Widowed | ⃝ Divorced | ⃝ Cohabitating |

**Sexuality**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Heterosexual (Straight) | ⃝ Male Homosexual | ⃝ Lesbian | ⃝ Bisexual | ⃝ Transexual |

**Height:** …………………………………………. **Weight:** ………………………………………………….. **BMI:** …………………………………………..

**Have you** ever suffered from? (tick as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy | ⃝ Yes ⃝ No | Blindness / Glaucoma | ⃝ Yes ⃝ No |
| High Blood Pressure | ⃝ Yes ⃝ No | Diabetes | ⃝ Yes ⃝ No |
| Heart Attack / Stroke | ⃝ Yes ⃝ No | Depression | ⃝ Yes ⃝ No |
| Cancer | ⃝ Yes ⃝ No | Asthma | ⃝ Yes ⃝ No |
| Eczema / Hay Fever | ⃝ Yes ⃝ No | COPD | ⃝ Yes ⃝ No |
| OCD  | ⃝ Yes ⃝ No | Bipolar Disorder | ⃝ Yes ⃝ No |
| Anxiety | ⃝ Yes ⃝ No | PTSD | ⃝ Yes ⃝ No |

**Are you currently taking any medication?** ⃝ Yes ⃝ No

**If so please specify** ………………………………….…………………………………………………………………………………………………………………

**Are you allergic to any medication?** ⃝ Yes ⃝ No

**If so please specify** ………………………………….…………………………………………………………………………………………………………………

**Date of last smear (if applicable)** ………………………………………………………………………………………………………………………………

**Date of last mammogram (if applicable)** …………………………………………………………………………………………………………………..

**Are registered disabled?** ⃝ Yes ⃝ No

**If so please specify** ………………………………….…………………………………………………………………………………………………………………

**Do you have any learning disabilities?** ⃝ Yes ⃝ No

**If so please specify** ………………………………….…………………………………………………………………………………………………………………

**Do you have a carer?** ⃝ Yes ⃝ No If ‘yes’ please specify:

Name …………………………………………………………………………………………………………………………………………………………………………

Address………………………………………………………………………………………………………………………………………………………………………

………..…………………………………………………………………………………………………………………………………………………………………………

Home Tel:…………………………………………………………… Mobile: ……..………………………………………………………………………

**Do you look after someone?** ⃝ Yes ⃝ No If ‘yes’ please specify:

Name …………………………………………………………………………………………………………………………………………………………………………

Address……………………………………………………………………………………………………………………………………………………………………….

………..………………………………………………………………………………………………………………………………………………………………………….

Home Tel:…………………………………………………………… Mobile: ……..………………………………………………………………………

**Smoking**

**Do you smoke?** ⃝ Yes ⃝ No

**If ‘yes’ how many?** ………………………………….…………………………………………………………………………………………………………………

**If ‘no’ have you ever smoked?** ⃝ Yes ⃝ No

**Would you like advice on giving up smoking?** ⃝ Yes ⃝ No

**Alcohol**

**How many units per week?** ……………………………………………………………………………………………………………………………………….

One unit = ½ pint of beer or 1 small glass of wine or 1 single spirit

**MEN: How often do you have EIGHT or more drinks on one occasion?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Never | ⃝ Less than monthly | ⃝ Monthly | ⃝ Weekly | ⃝ Daily |

**Alcohol Continued…**

**WOMEN: How often do you have SIX or more drinks on one occasion?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Never | ⃝ Less than monthly | ⃝ Monthly | ⃝ Weekly | ⃝ Daily |

**How often during the last year have you been unable to remember the night before because you had a drink?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Never | ⃝ Less than monthly | ⃝ Monthly | ⃝ Weekly | ⃝ Daily |

**How often during the last year have you failed to do what was normally expected of you because of drinkning?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Never | ⃝ Less than monthly | ⃝ Monthly | ⃝ Weekly | ⃝ Daily |

**In the last year has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you should cut down?** ⃝ Yes ⃝ No

**Proof of identity (please bring one of the following with you when registering)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Passport | ⃝ Driving License  |  |  |  |

**Proof of Address (please bring one of the following with you when registering)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ⃝ Utility Bill | ⃝ Tenancy Agreement | ⃝ Solicitor Letter | ⃝ Council Tax Bill |  |

**We want to get better at communicating with our patients and want to make sure you can read and understand the information we send you, if you find it hard to read our letters or if you need someone to support you at appointments please let us know**