Confidential New Patient Health Questionnaire -West London Medical Centre

SURNAME Mr/Mrs/Miss/Mast./Ms/Dr ..……..…….....…… SEX: M/F

FIRST NAME(S)…… DATE OF BIRTH …….

ADDRESS**……**

…….. POSTCODE…….
TELEPHONE NUMBERS& EMAIL:

HOME……..WORK …….. MOBILE …….

email ……..

NEXT OF KIN:

NAME…… M/F RELATIONSHIP……..

TEL NO…… email…….

ETHNICITY: What ethnic group do you come from? ……..

CARER:
Do you look after another family member or friend who is disabled or very ill? YES/NO
If yes, please state name of the person cared for and relationship…….

MOBILITY/DISABILITY:
Do you have any problems which make it difficult to move around and/or to communicate? YES/NO
If YES please give details, as it will enable us to make the best arrangements for your care.

…….
OCCUPATION:
What is your present job/occupation? ……

SMOKING:
Do you smoke? YES/NO If YES how many? ……If NO, have you ever smoked? YES/NO
If Ex-smoker, how many did you smoke……..
How long did you smoke for …… when did you stop……..

ALCOHOL:
Do you drink alcohol? YES/NO
If YES, what do you normally drink? ..... how much do you drink per week? ……

SUBSTANCE MISUSE

Are you addicted to any drugs/substance? YES/NO
If yes, please give details? .....Do you wish to seek help? .....
Please give details if you have ever been addicted to drugs/substance in past……..
MEDICINES:
Are you taking any medicines at the moment? YES/NO

If YES, please list them (or attach a printed list if you have one)

…….

ALLERGIES:
Are you allergic to any medicines? YES/NO (If YES, please give details)

ILLNESSES/OPERATIONS
Have you ever had any of the following? If YES, please give details including duration.

ANXIETY/DEPRESSION YES/NO …….

ASTHMA YES/NO …….

CANCER YES/NO …….

DIABETES YES/NO …….

EPILEPSY YES/NO …….

HEART DISEASE YES/NO ……..

HIGH BLOOD PRESSURE YES/NO ……..

HYPOTHYROIDISM YES/NO ……..

MENTAL ILLNESS YES/NO ……..

OPERATIONS YES/NO ……..

STROKE YES/NO ……..

WOMEN ONLY:
How many pregnancies have you had? ……
If you have children under 16, what are their ages? .....

CERVICAL SMEAR:
When did you last have a cervical smear? ……
Where was the smear carried out? ……
What was the result? …….

SIGNATURE …….. DATE……..

YOUR ANSWERS WILL BE TREATED AS STRICTLY CONFIDENTIAL AND WILL HELP DOCTORS AND NURSES TO PLAN YOUR CARE AT THE SURGERY.

FOR SURGERY USE ONLY

Checked by ……..	Date ……
Proof of Identity ☐	Proof of Address ☐
Type of ID……..	Photo copies taken ☐