Shotton Lane Surgery

New Patient Health Check Questionnaire

Please complete this questionnaire as fully as possible at the time of registration and hand back to the receptionist. The information will help the nurses and doctors to make an initial assessment of your health which will help in your future treatment.

Title: …… Surname: …… Forenames: ……..

NHS Number: ……. Date of Birth: --- / ---- / ------

Marital Status: …… Gender: ……

Ethnicity: ……..

Language Preference: ……

Address: ……

…… Home phone: ……

…… Mobile phone: ……..……..

Postcode: ……

Do you consent to the practice contacting you by text message for invitations to health checks, vaccination reminders, and anything else relevant to your healthcare: **Yes / No**

We have an electronic method of contact available for patients to contact the surgery for non-urgent requests – do you consent to us contacting you via this method & if so please supply us with a preferred email address for this purpose: **Yes / No**

Email Address: ……..

Health Details

Height: ……..

Weight: ……..

Known Allergies:
……
……

Smoking / Vaping

Do you smoke / vape: **Yes/ No**

If Yes how many: Cigarettes per day: ……

Ounces of tobacco per day: ……...

Vapes per day: ……..

If no have you ever smoked & when did you stop: ……..

Alcohol

For the following question please answer to the best of your knowledge

we have provided a basic guide below to assist you:

750ml bottle of wine – 10 units

175ml glass of wine – 2 units

Single shot of spirits – 1 unit

70cl bottle spirits – 28 units

Pint lager/beer/cider – 2 units

Pint strong lager/beer/cider – 3 units

How many units of alcohol do you drink per week: ……

Family History

Do you have or is there any family history of the following (which you/family member has received treatment for):

	Do you have	Family History	Family member
Heart Disease / Angina	Yes / No	Yes / No	
Stroke	Yes / No	Yes / No	
Cancer	Yes / No	Yes / No	
Asthma	Yes / No	Yes / No	
Diabetes	Yes / No	Yes / No	
Epilepsy	Yes / No	Yes / No	
Hypertension	Yes / No	Yes / No	
Disorder of Thyroid	Yes / No	Yes / No	

Medication

Please give details of any mediation that you take (prescribed or over the counter treatments)

Name of Medication	Dosage

Past Medical History

Please give details of any treatments / medical conditions:

……
……
……
……
……

Carers

Do you have anyone who looks after you or your daily needs as a carer: **Yes / No**

If Yes would you like them to deal with your health affairs here: **Yes / No**

(a member of reception staff can help with these arrangements)

Do you care for anyone else: **Yes / No**

Military Veteran

Have you ever served in the Armed Forces*:* **Yes / No**

Communication

Do you have any communication/information needs relating to sensory loss and if so what are they and how would you like us to communicate with you:

……
……
……

Thank you for your time in completing this questionnaire