Hanham Health *health matters...*

NEW PATIENT QUESTIONNAIRE

Welcome to Hanham Health. Please complete all questions and return this form to us as soon as possible.

Title	Mr / Mrs / Miss / Ms / Other		
Surname			
Forename(s)			
Date of Birth			
Address Postcode:			
Email			
Tel Number	Home:	Mobile:	Work:
School attended (for school age children only)			

As a practice we wish to communicate with our patients and will send SMS / email with practice news, advice on your healthcare and appointment reminders

I consent to receive SMS ☐ **I consent to receive Email** ☐

You will only receive emails / texts from Hanham Health and you can opt out of this service at any time by notifying us in writing via our surgery email address Sgccg.L81079.enquiries@nhs.net

Ethnic origin: (please tick)

White British	White Other	Black Caribbean	Black African
Black Other Non Mixed	Black Other Mixed	Indian	Pakistani
Bangladeshi	Chinese	Vietnamese	Asian Other
Irish Traveller	Other	Not Recorded	

Communication & Information needs: (please tick)

Main spoken language English ☐ Other ☐ (please state) _____

Do you have any communication/information needs relating to a disability, impairment or sensory loss?

Yes ☐ No ☐

If yes, please provide further detail (e.g. large print documents preferred, email or text easier than telephone calls, interpreter required)

Height_____ Weight_____

Carers

Do you have a carer? Yes ☐ No ☐

If yes, please provide their details including name, address and telephone Number:

Are you a carer (Not as part of your paid job)? Yes ☐ No ☐

If yes, please ask one of our Reception team for a carers pack to complete. This will ensure you are entered onto our carers register. A copy of this pack is also available on our website, www.hanhamhealth.co.uk

Have you ever served in the armed forces, regular or reserves? Yes ☐ No ☐

If yes, you may be eligible for priority NHS treatment for any condition related to your time in service. You may also be eligible for veteran specific health services.

Medical History:

Please indicate if you have, or have ever had any of the following health conditions:

Asthma		Heart condition	
High Blood Pressure		Chronic Airways Disease (COPD)	
Chronic Kidney Disease		Diabetes	
Mental Health Problems		Epilepsy	
Obesity		Cancer	
Learning Difficulties			

Please provide any further relevant details:

Have you had any serious operations?

If so, please list:

For Female patients only:

Have you had a hysterectomy? Yes ☐ No ☐

What was the date of your most recent cervical screening test (smear): _____

Please list any regular medication taken: (Please attach a repeat slip if you have one)

Are you have any known allergies to any medicines or anything else? : Yes ☐ No ☐

If yes, Please provide further detail

Family History: Have any of your immediate family suffered from the following? If so, please specify your relationship and the age at which they were diagnosed with the condition:

	Relationship	Age when diagnosed	Comments
Heart attack / angina			
Diabetes			
Stroke			
Cancer (which type?)			
High blood pressure			
Other serious illnesses			

	Smoking	
a	Do you smoke?	**Yes / No / Never smoked**
	If yes, how many cigarettes per day?	
	If yes, how many cigars / other tobacco per day?	
b	Are you an ex-smoker?	**Yes / No**
c	If you are an ex-smoker how much did you smoke and when did you stop?	

*If you're trying to give up smoking, we can help. Studies show that your chances of success will be greatly improved if you get advice and support from health care professionals to help you stop smoking. Please contact the Practice to arrange an appointment with our smoking cessation advisers

Physical Activity: (please tick <u>one</u> box which applies to your current level of physical activity)

Avoid exercise ☐ light activity ☐ moderate activity ☐ Heavy exercise ☐

Alcohol Consumption:

How many units of alcohol do you consume per week? ……units per week

(1 unit = ½ pint beer, 1 spirit measure or 1 small glass wine)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
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	
					Total Score	

Questions	Scoring System					Your Score
	0	1	2	3	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	
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	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
How often in the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 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	
					Total Score	

Scoring: 0 – 7 Lower risk / 8 – 15 Increasing risk / 16 – 19 Higher risk / 20+ Possible dependence

PATIENT DECLARATION:

The information I have completed on this form is correct to the best of my knowledge.

Signed…… Date……...