Dr PMA Simpson and Partners
Reviewed March 2019

New Patient Health Questionnaire for Adults

Please complete as many questions as you can. The information will help the practice to provide better medical care for you. This information will be held in the strictest confidence as per Data Protection.
Please complete any areas with *

Your Contact Details*

Title
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname

Date of Birth

First Names

Occupation

Previous Surnames

Home Address

Postcode:

Home Tel
Mobile
Work Tel
Email
Please provide an email address where possible

Information About You*

Are you a military veteran Yes/No If yes which service…………………………………….
When were you discharged?

What is your height?
What is your weight?

What is your first language?

Ethnic Group*

White	British ☐	Irish ☐	Other ☐ Please State:	
Black	Caribbean ☐	African ☐	Other ☐ Please State:	
Asian	Indian ☐	Pakistani ☐	Chinese ☐	
	Other ☐ Please State:			
Mixed	White + Black ☐ Caribbean	White + Black African ☐		

White + Asian ☐ Other ☐ Please State:

Which of the following best describes how you think of yourself?

Heterosexual/ Straight ☐ Gay/ Lesbian ☐ Bisexual ☐

In another way (Please State):

Which of the following best describes how you think of yourself?

Woman (including trans women) ☐ Man (including trans man) ☐

Non- binary ☐ In another way (Please State):

Previous GP*

Name and Address of Previous GP

Medical Information*

Please list any serious illnesses / operations / accidents / disabilities and for women any pregnancy related problems) and the year they took place:

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

Please list any medicines being taken and the amount:*

Are you registered disabled?* (If yes, please give details) Yes / No

Are you allergic to any medicines and if so, which?*
Yes / No

Have you ever refused treatment/screening of any kind and if so, what?*
Yes / No

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

Anxiety	Yes / No	Depression	Yes / No
OCD	Yes / No	Bipolar Disorder	Yes / No

Do you have any other mental health issues?* (If yes please give details)

Are you receiving or have you received any treatment or therapy?* (If yes please give details)

Carers*

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

Women*
Have you ever had a cervical smear? Yes / No
(Please state the last date)

Smoking*

Do you smoke? Yes / No

If 'No', have you ever smoked? Yes / No

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

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

Alcohol*

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

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

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 what happened the night before because you had been drinking?

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 drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No ☐ Yes, on one occasion ☐ Yes, more than once ☐

Family History*

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.)

Next of Kin*

Please give name, address and telephone number of next of kin

For patients aged 65 and over or those with a chronic disease* (e.g. asthma or diabetes)

Have you had a flu vaccination? Enter date or 'never':

Have you had a pneumococcal vaccination? Enter date or 'never'

Signature:

Date: