**Charnock Health Primary Care Centre Today’s Date:**

**New Patient Health Questionnaire (Adults)**

Please complete this confidential questionnaire (one for each member of the family to be registered with the practice)

Please bring evidence of your identity (eg passport, photo driving licence) and proof of residency (eg utility bill showing your address)

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| Full Name: | | | | | | | | | | | | | | Telephone Numbers  Home:  Mobile: | | | | | | | | | |
| Mr / Mrs / Miss / Ms / Other…. | | | | | | | | | | | | | | Work Number: | | | | | | | | | |
| Address and Postcode | | | | | | | | | | | | | | Email Address: | | | | | | | | | |
| Your Date of Birth | | Any previous surnames | | | | | | | | | | | | I consent to the surgery texting me eg for appointment reminders Yes / No  If you want to book appointments and order medication online please let our receptionist know. You will need to provide ID for this. | | | | | | | | | |
| Marital Status |  | Sex: | | | | | Male Female  Other | | | | | | | Other Residents of your home: | | | | | | | | | |
| Is this the sex you were assigned at birth? | | | | |  | | | | | | |
| Occupation: | | | | | | | | | | | | | | Are you a foster carer/carer for any children?  If so, please give name and date of birth of child | | | | | | | | | |
| Next of Kin | | | | | Next of Kin contact number | | | | | | | | | | | | Next of Kin relationship to you | | | | | | |
| Your Ethnic Origin:  (select one) | | | White (UK) | | | | | | | | | White (Irish) | | | | | | White (Other) | | | | | |
| Caribbean | | | African | | | | | | | | | Asian | | | | | | Other Mixed background | | | | | |
| Indian / Brit Indian | | | Pakistani / Brit Pakistani | | | | | | | | | Bangladeshi / Brit Bangladeshi | | | | | | Other Asian Background | | | | | |
| Other Black Background | | | Chinese | | | | | | | | | Other | | | | | |  | | | | | |
| Your Religion: | | | C Of E | | | | | Catholic | | | | Other Christian (state) | | | | | | Buddhist | | | Hindu | | Muslim |
| Sikh | | | | | Jewish | | | | Jehovah’s Witness | | | | | | No Religion | | | Other Religion (state) | | |
| Your main or 1st language spoken/understood: | | | | | | | | | | | | | | | | | | | | | | | |
| **Your Medical Background:** | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever had?  If YES please specify date | | | | High blood pressure  YES / NO | | | | | | | Epilepsy  YES / NO | | | | | Asthma  YES / NO | | | | Kidney Disease  YES / NO | | | |
| Heart Disease/Heart Failure/Atrial Fibrillation  YES / NO | | | | | | | Stroke  YES / NO | | | | | Diabetes  YES / NO | | | | Peripheral Vascular Disease  YES / NO | | | |
| Other serious illnesses or operations (with dates) | | | |  | | | | | | | | | | | | | | | | | | | |
| Are you undergoing any regular treatment  or follow-up? | | | |  | | | | | | | | | | | | | | | | | | | |
| **If you are on any current medication please ensure that you have a month’s supply from your previous surgery and send a copy of the right side of your prescription with your registration forms.** | | | | | | | | | | | | | | | | | | | | | | | |
| If you are on repeat medication, which pharmacy would you like your prescriptions to go to? | | | |  | | | | | | | | | | | | | | | | | | | |
| Are you able to administer your own medicines? | | | | YES | | | | | | | NO- please detail specific issues (e.g. swallowing, opening containers) | | | | | | | | | | | | |
| Do you have any allergies? | | | |  | | | | | | | | | | | | | | | | | | | |
| Have any of your near family (parents, grandparents, brothers or sisters) ever suffered from? | | | | Diabetes (who?) | | | | | | Asthma (who?) | | | | | | Stroke (who/age?) | | | | Heart Disease (who/age?) | | | |
| High Blood Pressure (who?) | | | | | | Cancer of the bowel (who/age) | | | | | | Breast Cancer (who/age?) | | | | Osteoporosis (who/age?) | | | |
| Do you know your weight? (in kg) | | | | | | | | | | | | | Do you know your height? (in cm) | | | | | | | | | | |
| **Lifestyle:** | | | | | | | | | | | | | | | | | | | | | | | |
| Are you a current smoker? | | | | Yes | | | | | No | | | | | Have you ever been a smoker? | | | | | Yes | | | No | |
| If yes, how many cigarettes/ cigars/ tobacco you smoke in a day? | | | |  | | | | | *If you are a smoker and want to stop, please ask for information about local smoking cessation services* | | | | | | | | | | | | | | |
| How often do you exercise? | | | | | | No. times per week | | | | | | | | | Type (s) of exercise: | |  | | | | | | |
| **Blood Pressure**  *If you have not had your blood pressure checked in the last 5 years, please book in with one of our Health Care Assistants for this taking.* | | | | | | | | | | | | | | | | | | | | | | | |

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| Specific Needs:  Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action: | | |
| Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight): |  | |
| Are you an ‘Assistance Dog’ User? |  | |
| Please state any Physical disabilities you have: |  | |
| Please state any Mental disabilities you have: |  | |
| Please state any requirements you have to be able to access the Practice premises |  | |
| Please state any Religious or Cultural needs: |  | |
| Do you require the help of a Translator/Interpreter? |  | |
| Are you a Carer? | YES NO  Their relationship to you:- | |
| If you have a Carer, please state their name/address/phone number and sign here if you wish us to disclose information about your health to your Carer. | Carer Contact Details  Their relationship to you:- | |
| Signed : Date: | |
| Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? | YES / NO | If ‘Yes’, please state their name/address/phone number: |
| **Women only:** | | |
| When was your last smear taken? (Date) | Was this done at your GP Surgery? YES / NO | |
| Date of last mammogram (if applicable): | Method of contraception (if used): | |
| **Signature of Patient:** | **Signature on Behalf of Patient:** | |

**Alcohol use disorders identification test consumption (AUDIT C)**

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| **Questions** | **Scoring system** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per months | 2 to 3 times per week | 4 or more times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more |  |
| 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 |  |

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| **AUDIT C Score** |  |

**Scoring:**

A total of 5 or more is a positive screen

0 to 4 indicates low risk

5 to 7 indicates increasing risk

8 to 10 indicates higher risk

11 to 12 indicates possible dependency

**PLEASE ENSURE ALL FORMS ARE COMPLETED BEFORE SENDING**