# Lincoln House Surgery
## 163 London Road, Hemel Hempstead, HP3 9SQ

| Date Form Completed: | |
|---|---|

**In order to be fully Registered with this practice, this form MUST be completed**

| NEW PATIENT HEALTH QUESTIONNAIRE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **TITLE** | | | | | | | |
| **FIRST NAME** | | | | | | **Name you would like Dr or Nurse to use:** | |
| **SURNAME** | | | | | | | |
| **DATE OF BIRTH** | | **SEX** | **M** | **F** | **MARITAL STATUS** | | |
| | | | | | | | |
| **ADDRESS** | | **ARE YOU A CARER FOR SOMEONE?**<br><br>**If yes, please specify who:** | | | **YES / NO** | | |
| **HOME TEL:** | | **WORK TEL:** | | **MOBILE TEL:** | | | |
| **NEXT OF KIN:**<br>**Name, Address, Tel No.** | | | | | | | |
| **OCCUPATION** | | | | | | | |
| **ARRIVED FROM ABROAD**<br>**What date?** | | | | | | | |
| **SMOKING HABIT** | | | | | | | |
| **Are you a current smoker?** | | **If Yes** | | | **If No** | | |
| | | **No. Cigarettes per day?** | | | **Have you ever smoked?** | | |
| | | **No. Cigars per day?** | | | **Year Stopped** | | |
| | | **Pipe tobacco per week?** | **Oz/gr** | | **How many *did* you smoke per day?** | | |
| | | **Would you like help to stop?** | | | | | |

| ALCOHOL INTAKE | |
|---|---|
| **Do you drink alcohol?**<br>**If Yes:** | **YES / NO** (please circle) |
| **Wines / Spirits: units per week** | |
| **Beer: units per week** | |
| **(1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer)** | |

| EXERCISE HABIT | |
|---|---|
| **Do you take regular exercise?**<br>**If Yes, which statement applies:** | **YES / NO** (please circle) |
| **Enjoy light exercise?** | |
| **Enjoy moderate exercise?** | |
| **Enjoy heavy exercise?** | |

| **ARE YOU ON ANY REGULAR MEDICATION? (including the contraceptive pill)** | **YES / NO** (please circle) |
|---|---|
| **If Yes, please state name and dose**<br><br>**(Please note you will be required to see the doctor for a first Repeat prescription to be issued)** | |
| **ARE YOU ALLERGIC TO ANY MEDICINES?** | **YES / NO** (please circle) |
| **If Yes, please state type and name.** | |
| **DO YOU HAVE ANY OTHER ALLERGY?** | |
| **If Yes, please state type and describe.** | |

| WOMEN ONLY | | | | | |
|---|---|---|---|---|---|
| **Date of Last Smear?** | | **What was the Result?** | | **Where was it taken?** | |
| **No. of Pregnancies?** | | **No. of Children?** | | **Are you pregnant now?** | |

# MEDICAL HISTORY

**Do you have/have you had any of the following conditions?**
**(please circle) :**

| | | | |
|---|---|---|---|
| **High Blood Pressure** (Please add Approximate date if known) | **YES / NO** | **Diabetes** (Please add Approximate date if known) | **YES / NO** |
| **Heart Disease** (Please add Approximate date if known) | **YES / NO** | **Angina** (Please add Approximate date if known) | **YES / NO** |
| **Epilepsy** (Please add Approximate date if known) | **YES / NO** | **Stroke** (Please add Approximate date if known) | **YES / NO** |
| **Asthma** (Please add Approximate date if known) | **YES / NO** | **Cancer** (Please add Approximate date if known) | **YES / NO** |
| **Have you used your inhaler in past 12 months?** | **YES / NO** | | |

**Please give details of any other illnesses, accidents, hospital admissions, investigations or operations:** ***(Please continue on a separate sheet if necessary)***

| | |
|---|---|
| | **Date** |
| | **Date** |
| | **Date** |
| | **Date** |

# FAMILY HISTORY

**Has a first degree relative (parent or brother or sister) suffered from any of the following conditions?**
**(please circle)**

| | | | |
|---|---|---|---|
| **Cancer** | **YES / NO** | **Who?** | **At what age?** |
| **Stroke** | **YES / NO** | **Who?** | **At what age?** |
| **Heart Disease** | **YES / NO** | **Who?** | **At what age?** |
| **Diabetes** | **YES / NO** | **Who?** | **At what age?** |

**Do any other illnesses run in your family? YES / NO**
**If Yes, Please give details :**

**Please give details of the current state of your family's health :**

| | Age | State of Health | Age at death | Cause of Death |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Brother/Sister** | | | | |

# ETHNICITY & INTERPRETER NEEDS QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

**NAME** _____ **DOB** _____

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

If you **do** need an interpreter, what language do you speak?

| **Please state:** |
|---|
| |

**WHAT IS YOUR ETHNIC GROUP?**

Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

| **A. White** | |
|---|---|
| British | |
| Any other white ethnic group, please specify below: | |
| | |
| **B. Mixed or multiple ethnic groups** | |
| Any mixed or multiple ethnic group | |
| **C. Asian or Asian British** | |
| Pakistani or Pakistani British | |
| Indian or Indian British | |
| Bangladeshi or Bangladeshi British | |
| Chinese or Chinese British | |
| **Other, please specify:** | |
| | |

| **D. African, Caribbean or Black** | |
|---|---|
| African or African British | |
| Caribbean or Caribbean British | |
| Black or Black British | |
| **Other, please specify:** | |
| | |
| **E. Other ethnic group, please specify:** | |
| | |

| If you would prefer not to provide this information, please tick here: | |
|---|---|

**Surgery Use Only:**

| | | | |
|---|---|---|---|
| **BP:** | **Weight:** | **Height:** | **BMI:** |
| **Urine:** | **Protein:** | **Glucose:** | **Other:** |

**NOTES/ACTION/DISCUSSION:**