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?** **If yes, please specify who:**			**YES / NO**			
HOME TEL:		**WORK TEL:**		**MOBILE TEL:**				
NEXT OF KIN: **Name, Address, Tel No.** **Relationship:**								
OCCUPATION								
ARRIVED FROM ABROAD **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? **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? **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 **(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

Your Height: **Your Weight:**

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: