Park Lane Surgery
Redmarshall Street
Stillington
TS21 1JS

New Patient Health Questionnaire

Your Contact Details

Title
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Surname ……

Date of Birth…… First Name(s)……

Home Address

Home Tel ……..
Mobile……..
Work Tel……

Email

Information About You

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:

Medical Information (Long Term Conditions, Operations, Illness)

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

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.)

Signature:

Date: