EVERSLEY MEDICAL CENTRE

Date form completed

CONFIDENTIAL HEALTH QUESTIONAIRE FOR NEW PATIENTS
ADULTS ONLY

Have you been registered with this surgery before?
If yes, when? ……

Please complete every section. If you do not have the information or the section does not apply to you, then please write this as your answer and then move on to the next question. There is a section at the end of the form if you need to explain something concerning your health, in more detail.

Last Surname	**First name**	**Middle name**

Address	**Home** **Work** **Mobile**

DOB	**Gender**	**Male**		**Female**	

Marital status – please tick one of the following	**Single**	**Married**	**Cohabiting**	**Separated**	**Divorced**	**Widowed**

Are you a carer?	Yes		No	
Do you have a carer ?	Yes		No	

City and country of birth_____	If you were born overseas, when did you move to England Month …….. Year ……

Ethnicity – please tick box applicable to you

White	White British		**Mixed background**	White & black Caribbean	
	White Irish			White & black African	
	White other- please state			White & Asian	
				Other mixed – please state	
Asian or Asian British	Asian or British Asian - indian		**Black**	Black Caribbean	
	Asian or British Asian - Pakistani			Black African	
	Asian or British Asian - Bangladeshi			Black British	
	Asian or British Asian – other Background – please state			Black – other background – please state	
Chinese or other ethnic groups	Chinese				
Other ethnic group			**I do not wish to disclose my ethnicity**		

PERSONAL MEDICAL HISTORY

Please tick is you suffer or have suffered from any of the conditions listed below						Please detail any other serious or chronic illnesses, operations or disabilities
Asthma		**Diabetes**		**Heart trouble**		
Cancer		**Yellow Jaundice**		**High blood pressure**		
Glaucoma		**Tuberculosis**				

Are you allergic to anything?	**No**		**Yes – please give details of your allergies below**

Allergies:

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Are you currently taking any drugs or medicines? If yes please list then below

Have any of your close relatives, parents, brothers, sisters, ever suffered from any significant medical problems? Please give details below for example, Asthma, diabetes, High Blood Pressure, Stroke, Heart attack or Angina, Epilepsy, Migraine, Glaucoma, Cancer, Tuberculosis, Mental Health

Relative	Problem	At what age

LIFESTYLE

Do you smoke?	Yes		No		Never smoked tobacco		Pipe smoker				
Stopped smoking					Cigar smoker		Roll own cigarettes				
Pipe smoker					Pipe smoker		Pipe smoker				
Less than 1 cigarette/day					Trying to give up smoking		1-9 cigarettes / day				
Thinking about giving up smoking					10-19 cigarettes		20-39 cigarettes/day				
More than 40 cigarettes /day					Would you like information on how to give up smoking?		Yes		No		

FOR FEMALE PATIENTS ONLY

Are you using any contraception	no		Yes – please state what you and /or your partner are using		
Have you ever been pregnant	Yes		No		If yes , please state enter the following details

Year of pregnancy	Any problems	What happened?	Normal birth	Caesarean	Miscarriage	termination

Have you had a cervical smear before	**Yes**		**No**		**Have you had a smear test since then at a clinic/hospital?**	**Yes**		**No**		**Have you ever had an abnormal smear result?**	**Yes**		**No**	
Have you had a hysterectomy	**Yes**		**No**		**Have you ever had a mammogram?**	**Yes**		**No**		**Was the mammogram normal?**	**Yes**		**No**	

TO ALL NEW PATIENTS

You are also able to book appointments and view your medical information. Please tick the boxes to say what you would like access too

Booking appointments		**Requesting medication**		**Access to you summary medical record online**	

If you wish to see your summary medical record online please read and agree with each statement (please tick a-e)

a. I have read and understood the information leaflet provided by the practice	
b. I will be responsible for the security for the information that I see or download	
c. If I choose to share my information with anyone else, this is at my own risk	
d. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
e. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	

Signature of patient	**Print name**

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For Reception Use Only

Patient NHS no		**Patient Emis. no**	
Identification verified by (Initials)	**Date**	**Method**	
		Couching	
		Vouching with information in record	
		Photo ID and proof of residence	

Type of document	**Driving licence**		**Passport**		**National id**		**Other**	
Document no								
Country of issue								

Clinical Use			
Signature of Authorising clinician		**Date**	

For Online Password Issuer only			
Date account created		**Level of access enabled**	
Date password issued		**Prospective**	
Retrospective		**All**	
Limited parts		**Contractual minimum**	

PPG information

PPG information given			
Patient interested; Contact information	**Patient contact number**	**Mobile**	**Landline**
Patient interested in online participation	**Patient Email address:**		