NEW PATIENT REGISTRATION HEALTH QUESTIONNAIRE
City Health Practice

Southcoates Medical Centre – 225 Newbridge Road, Hull, HU9 2LR
Marfleet Lane Surgery – 358 Marfleet Lane, Hull, HU9 5AD

Dear Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. You will also be invited to attend a new patient assessment as part of your registration.

PLEASE NOTE WHEN YOU BRING THESE COMPLETED FORMS BACK TO THE SURGERY WE WILL NEED TO SEE PROOF OF ID (PREFERABLY PHOTO ID) AND PROOF OF ADDRESS. WITHOUT THESE WE CANNOT REGISTER YOU.

Date of completion of this form: __ __/__ __/__ __

Surname: ....

Forename(s): ....

Date of Birth: __ __ /__ __ /__ __ __ __ Marital status: ....

Address: ....

.... Postcode: ....

Home Tel: __ __ __ __ __ __ __ __ __ __ __ __ Mobile: __ __ __ __ __- __ __ __ __ __ __

Work Tel: __ __ __ __ __-__ __ __ __ __ __ __ Occupation: ....

Email: ....

Next of Kin name: .... **Relation**: ....

Contact number: __ __ __ __ __ - __ __ __ __ __ __ **Mobile**: __ __ __ __ __ __ __ __ __ __ __

Weight (Approx): .... Height: ....

SMOKING

Do you smoke? **YES / EX-SMOKER / NEVER SMOKED**

If Yes, how many:

Cigarettes per day .... Cigars per day .... Ounces of tobacco per day ....

How old were you when you started smoking? ....

EX-SMOKERS

How old were you when you stopped smoking? ………… How much did you smoke per day? ……………..

PASSIVE SMOKING

Are you exposed to smoke at work? **YES / NO** At home? **YES / NO**

We offer an in-house Stop Smoking Clinic. Would you like to attend? **YES / NO**

If yes please contact the reception team for more information. Alternatively, you may wish to contact the NHS Free Smoking Helpline: **0800 022 4 332**

ALCOHOL

How many units of alcohol do you drink per week? ……………………………………………..

(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)

DIET

Do you add salt to your food after cooking? **YES / NO**

Do you have a varied diet including milk, meat, vegetables and fruit? **YES / NO**

Has your Cholesterol been checked in the last 2 years? **YES / NO**

EXERCISE

Do you take regular exercise? **YES / NO**

If yes, what sort of exercise? ……………………………………………………………………………………………

How many times per week? ………………………………………………………………………..

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? ………………………………….

Stroke? Yes / No Which family member? ………………………………….

Cancer? Yes / No Which family member? ………………………………….

Site of cancer? ……………………………………………………………

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……………………………………

Dosage: ………………………………………………..

Name of drug: ……………………………………

Dosage: ………………………………………………

* * * If you are on regular medication, please provide the counter foil of your previous repeat prescription, or bring all box's of your medication which will have your name printed and dosage of your medication. We cannot accept a hand written note.
You may also be advised to book a routine appointment with the GP for a medication review, please speak with our Reception Team for further advice * * *

ALLERGIES

Are you allergic to any substances or foods? **YES / NO**

If yes, please give details: ....

....

....

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient: ....

....

....

....

Please give details of any treatment for any chronic medical conditions: ....

....

....

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound: ....

....

....

IMMUNISATIONS

Dates of Triple/polio/HIB: ....

Dates of MMR: ....

Date of last Tetanus: ....

FEMALE PATIENTS

Date of most recent cervical smear: ....

Result of most recent smear: ....

Please give details of any complications in pregnancy: ....

....

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? **YES / NO**

If "Yes", would you like them to deal with your health affairs here? **YES / NO**

(The receptionist can help with these arrangements)

Do you care for anyone else? **YES / NO**

If "Yes", ask the receptionist about Carers support

DISABILITY STATUS

Are you registered Disabled? **YES / NO / DECLINED**

If registered or have been registered within Military Services please can you supply with dates:

Date Joined Military Service ....
Date Left Military Service ....

Patient Ethnicity, Language & Literacy

Ethnicity (tick one)

- ☐ White British
- ☐ White Irish
- ☐ Other white ethnic group
- ☐ Pakistani
- ☐ Indian
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other Asian ethnic group
- ☐ Black African
- ☐ Black Caribbean/West Indian/Guyana
- ☐ Other black ethnic group
- ☐ Black African and white
- ☐ Other ethnic, Asian/white origin
- ☐ Black Caribbean and white
- ☐ Other ethnic group

Country of birth ☐

Religion ☐

Language (tick one)

- ☐ Speaks English well
- ☐ Speaks English poorly

Main spoken language ☐

Interpreter needed ☐ Using British sign language ☐

Reads English ☐ Ability to write ☐

Thank you for completing this questionnaire.

Please arrange a 20 minute appointment for a New Patient Health Check with our Healthcare Assistant. You will also be asked to bring a Urine Sample with you to this appointment.

It is important that you attend in order to fully complete your registration.

You will be asked to provide a urine sample during your appointment to check for Diabetes, please collect a specimen bottle from reception.

All appointments are very valuable to us. If you are unable to attend please contact the surgery as soon as possible to rebook so that we can offer your appointment to someone else. Missed appointments could lead to removal from Practice list.

We look forward to seeing you at your appointment.

Enclosure: Summary Care Records Leaflet (please ask at Reception if not included)