***DEAL TREE HEALTH CENTRE***

**New Patient Health Check Medical History Form**

*A copy of this form should be completed for* ***each*** *member of the family*

1. **PERSONAL DETAILS**

Title: Mr Mrs Miss Ms Other ……….

Surname: …………………………………………….……………. Date of Birth: ….……. / …….…. / …….………..

Forenames: …………………………………………………………..…………………………………………………………………………………..

**Marital Status:** Single Married with Partner Widowed Divorced Separated

Full Address: ………………………………………………………………………………………………………………….……….

………………………………………………………………………………………………. Post Code: ………………………..

E-Mail Address: ………………………………………………………………………………………………………………..…….

Home ‘Phone No: ………………………………………………. Mobile No: ………………………………….……….

**PLEASE NOTE: BY PROVIDING YOUR MOBILE NUMBER YOU ARE CONSENTING TO RECEIVE TEXT MESSAGES RELATING TO APPOINTMENTS, CLINIC REMINDERS AND OTHER GENERAL INFORMATION. IT IS IMPORTANT THAT YOU ADVISE US OF ANY CHANGE IN YOUR NUMBER.**

Daytime/Work Contact No: ……………………………………. Occupation: ……………..……………………..

Place of Birth: Town: ………………..……. County: ………..…………….... Country: ……….....……..…

Full Name & Address of previous Doctor: …………………………………………………….…………………………

………………………………………………………………………………………………………………………………………………….

1. **ARE YOU A CARER? No / Yes**

2a **TO REGISTER FOR ONLINE SERVICES & PRESCRIPTIONS? No/Yes**  **PHOTO I.D. NEEDED**

3. **PATIENT PARTICIPATION GROUP** – This Practice is committed to improving the services we provide to our patients, to do this it is vital that we hear from people like you about your views and experiences. Please let us know if you are interested **YES/NO,** or ask Reception for an application form

1. **WEIGHT:** …………………………………. **HEIGHT:** …………………………………………

5. **ALLERGIES:** Please give details of any allergies (e.g. medicines, eggs, nuts, vaccines or chickens)

|  |  |
| --- | --- |
| **Cause** (e.g. drug name) | **Nature of Reaction** (e.g. rash, lip swelling) |
|  |  |
|  |  |

**6. PRESENT MEDICATION** (Please list all medicines, pills, inhalers, etc.,)

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**\* Please speak to Dispensary if you wish to nominate a Chemist for electronic prescriptions**

**PLEASE MAKE AN APPOINTMENT TO SEE THE DOCTOR IF YOU ARE ON REGULAR REPEAT MEDICINES.**

**7. MEDICAL HISTORY:** Do you have or ever had any of the following? Please tick Yes or No and give dates suffered and details where appropriate:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONDITION** | **Y** | **N** | **DATE** | **DETAILS** |
| Asthma |  |  |  |  |
| Chronic Bronchitis/Emphysema |  |  |  |  |
| Stomach or bowel trouble |  |  |  |  |
| Cancer |  |  |  |  |
| Diabetes |  |  |  |  |
| Epilepsy / Fits |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Thyroid Trouble |  |  |  |  |
| Stroke |  |  |  |  |
| Mental Health Problems |  |  |  |  |
| Heart Attack |  |  |  |  |
| Angina |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Other (give details) |  |  |  |  |

**8. FAMILY HISTORY:** Please list any close family (Mother, Father, Sister/Brother) who have had any of the above illness and at what age.

.………………………………………………………………………………..……………………………………………………………………………………………………………………………………………………………………………………………………………………………

**9. IMMUNISATIONS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TYPE** | **DATE** | **TYPE** | **DATE** | **TYPE** | **DATE** |
| Tetanus |  | Rubella |  | Typhoid |  |
| Diphtheria |  | Polio |  | Hepatitis A |  |
| Measles |  | Whooping Cough |  | Hepatitis B |  |
| Mumps |  | TB |  | Other: |  |

**10. WOMEN-ONLY QUESTIONS:**

Have you had a Cervical Smear: YES / NO If yes, date of last smear: ………………………………………

Result of last Smear: ………………………………………………………………………………………………………………………………

Are you currently pregnant? YES/NO If yes, expected date of delivery ……………………………………………

**11. OTHER INFORMATION:** Please write below details of any other information you feel should be included in your medical records, for example serious accidents or operations (continue on a separate sheet if necessary):

………………………………………………………………………………………………………..………………………………………………............................................................................................................................................................................................................................................................................................................................

Signed: ……………………………………………………………….. Date:

***SMOKING STATUS***

Please provide the following information so we can update your records accordingly:

**NAME:** ………………..…….…………………………. **Date of Birth:** ……………………………….………

**ADDRESS:** ………………………….………………………………………………………………………………………

**Are you currently a:**

Smoker, if so how many a day

Ex-Smoker Date stopped …………………………………..

Never Smoked

**Would you like to help Quit?**

Yes

No

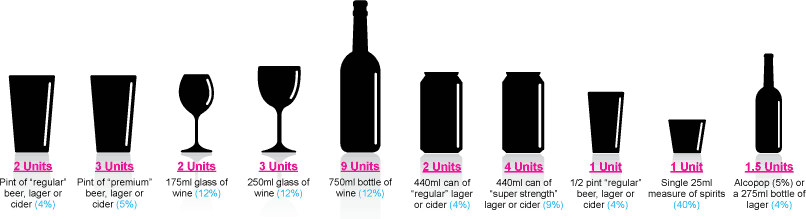
**Would you be happy for us to contact you regarding services available in the future?**

Yes

No

**ALCOHOL SCREENING**

**NAME:**

**UNIT GUIDE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT – C Question** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |  |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often in the past year have you found that you were not able to stop drinking once you had started | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the past year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Has a relative or a doctor of other health worker been concerned about your drinking or suggest you cut down | No |  | Yes, but not in the past year |  | Yes, during the past year |  |
| **TOTAL** | | | | | |  |

A score of **less than 5** indicates lower risk drinking **Scores of 5+** requires the following 7 questions to be completed:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT – C Question (9K15).** After completing 3 AUDIT-C questions above) | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |  |
| How often during the last year have you found that you were not able to stop drinking once you had started: | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the past year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking | Never | Less than monthly | Monthly | Weekly | Daily or almost 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 or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down | No |  | Yes but not in the last year |  | Yes, during the last year |  |
| **TOTAL** | | | | | |  |

***If your total score indicates an increased risk, you may be invited for a health screen with a Nurse / Doctor or be given further information regarding safe alcohol consumption***

**GENERAL PRACTICE PHYSICAL ACTIVITY QUESTIONNAIRE**

Name: ……………………………………………………………………………

Date of Birth: …………………………………………………………………………….

1. Please tell us the type and amount of physical activity involved in your work

|  |  |  |
| --- | --- | --- |
|  | | Please mark one box only |
| A | I am not in employment (e.g.: retired, retired for health reasons, unemployed, full-time carer, etc. |  |
| B | I spend most of my time at work sitting (such as in an office) |  |
| C | I spend most of my time at work standing or walking. However, my work does not require much intense physical effort, (e.g.: shop assistant, hairdresser, security guard, child minder, etc.) |  |
| D | My work involves definite physical effort including handling of heavy objects and use of tools (e.g.: plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery worker, etc.) |  |
| E | My work involves vigorous physical activity including handling of very heavy objects, (e.g. scaffolder, construction worker, refuse collector, etc.) |  |

1. During the last week, how many hours did you spend on each of the following activities: *Please answer whether you are in employment or not*.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | None | Some but less than 1 hour | 1 hour but less than 3 hours | 3 hours or more |
| A | Physical exercise such as swimming, jogging, aerobics, football, gym workout, etc. |  |  |  |  |
| B | Cycling, including cycling to work and during leisure time |  |  |  |  |
| C | Walking, including walking to work, shopping for pleasure, etc. |  |  |  |  |
| D | Housework / Childcare |  |  |  |  |
| E | Gardening / DIY |  |  |  |  |

1. How would you describe your usual walking pace, Please mark one box only?

Slow place Steady Brisk Fast pace

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

(i.e.: less than average pace (i.e.: over

3 mph) pace 4 mph)

***ETHNICITY QUESTIONNAIRE***

Please COMPLETE AND RETURN THIS Questionnaire as part of our welcome pack:

**NAME:** ……………..…….…………………………. **Date of Birth:** ……………………………………

I would describe my ethnic origin as:

British or Mixed British

English

Irish

Scottish

Welsh

Or any other? Please specify if you wish ………………………………………………………….

**Asian**

Bangladeshi

Indian

Pakistani

Any other Asian background? Please specify if you wish …………………………………..

**Black**

African

Caribbean

Any other Black background? Please specify if you wish ……………………………………

**Chinese**

Any Chinese background

**Mixed Ethnic background**

Asian and White

Black African and White

Black Caribbean and White

Any other Mixed background? Please specify if you wish ……………………………………

Any other White background? Please specify if you wish ……………………………………

Any other White background? Please specify if you wish ……………………………………

**Language**

What is your main spoken language ………………………………………………………………….

Are you an English speaker YES NO