WELLS HEALTH CENTRE
BOLTS CLOSE, WELLS-NEXT-THE-SEA, NR21 1JP
Tel. 01328 710741 (www.wellshealthcentre.nhs.uk)

NEW PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

INTRODUCTION

Firstly a very warm welcome to Wells Health Centre.

This questionnaire is used to capture data for all New Patient Registrations and it also helps to establish and identify a baseline view of your life-style and will assist the Practice Nurse/Doctor in carrying out your new patient health check. The information provided will assist also in the identification of "at risk" patients and focus care advice on at risk areas. Please complete this questionnaire as fully as possible. You will be required to attend a new patient assessment.

Thank you for completing this questionnaire.

Your Details:
Surname: …… Forename(s): ……..
Date of Birth: …… Marital status: ……
NI No……..

Address: ……..
……Postcode: ……..
Home Tel No: …… Mobile……..
Email address……
What is your first language?……
Occupation: ……..

Please circle below that which most closely matches your occupation:
Professional; Managerial; Skilled; Semi Skilled; Unskilled; Unemployed; Retired

Weight (approx): …… Height: ……

Next of kin & relationship to you - Name/address/phone no.
……
……
……

ETHNIC ORIGIN

How would you describe your racial background (You do not have to fill this in, if you do not want to just tick the box "Do not wish to say")

·	British or mixed British	·	Bangladeshi or British Bangladeshi
·	Irish	·	Other Asian background
·	Other White background	·	Caribbean
·	White and Black Caribbean	·	African
·	White and Black African	·	Other Black
·	White and Asian	·	Chinese
·	Other Mixed background	·	Other
·	Indian or British Indian	·	Do not wish to say
·	Pakistani or British Pakistani		

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

EXERCISE
Do you take regular exercise? Yes / No
If yes, what sort of exercise? ……
How many times per week? ……..

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
Do you have a restricted diet? Yes /No If Yes, give details:……
Has your Cholesterol been checked in the last 2 years? Yes / No

ALCOHOL
For the following questions please circle the answer which best applies to yourself.
1 drink = **1/2 pint of beer** or **1 glass of wine** or **1 single spirit**

1. How often do you have a drink that contains alcohol?
Never; Monthly or less; 2-4 times per month; 2-3 times per week; 4+times per week

2. How many alcoholic drinks do you consume per week? ……..

3. How many standard alcoholic drinks do you have on a typical day when you are drinking?
1-2; 3-4; 5-6; 7-9; 10+

4. How often do you have 6 (8 if a man) or more standard drinks on one occasion?
Never; less than Monthly; Monthly; Weekly; Daily or almost daily

5. 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

6. 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 or almost daily

7. In the last year has a relative, friend, doctor or health worker been concerned about your drinking of suggested you cut down?
No: Yes, on one occasion; Yes, on more than one occasion

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…….

High Blood Pressure Yes / No Which family member…….

Diabetes Yes / No Which family member? …….

Asthma Yes / No Which family member? …….

Glaucoma 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: ……..

Name of drug: ……

Dosage: ……..

YOUR DRUG / FOOD 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 dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

……..

……

Please list any Medical Illness

(e.g.Diabetes/Epilepsy/TB/Asthma/Bronchitis/Thyroid Disease/Heart/Liver/Kidney Disease/High Blood Pressure/Cancer /Osteoporosis) and the date it was diagnosed:

Date …….. Problem ……..

Date …….. Problem ……..

Date …….. Problem ……..

FEMALE PATIENTS

Date of most recent cervical smear: ……..

Result of most recent smear: …….

Please give details of any complications in pregnancy:

……..

Have you been vaccinated against German Measles (Rubella)? Date:……..

Are you using any form of birth control which requires medical follow up (Pill, Coil, etc)? Yes / No If yes, which……

Have you any disorders of the breasts? Yes / No

Have you had a Mammogram? Yes / No
If Yes, when and what was the result? …….
How many children do you have? …….
Are any of your children handicapped or unwell? ……

SERVICES USED
Meals on Wheels: Yes / No
Home Help: Yes / No
Day Centre: Yes / No

Type of accommodation you live in: (please circle)
House; Upper Flat; Lower Flat; Sheltered; Residential Home

Help Required:
District Nurse; Social Worker; Chiropodist; Occupational Therapist; Physiotherapist

CARERS
Do you have a carer? Yes / No
If "Yes", would you like them to deal with your health affairs here? Yes / No

Do you care for anyone else? Yes / No

DISABILITY
Do you have a disability, e.g. blind, deaf, some hearing or visual loss, learning disability, which may require help regarding accessibility to your records, communication, health information, etc.

OTHER INFORMATION
Any other information you wish us to record?

ALLOCATED NAMED GP
Your allocated named GP will be Dr McAnsh who, as Senior Partner, is responsible for your overall care. However, you can see which ever GP you prefer.

Date of completion of this form: / / (DD/MM/YYYY)

******Please provide a form of photo ID, i.e. passport or driving licence; and also Address ID, e.g. utility bill, bank statement, etc.******