 FOUNTAINS

Fountains Health

2nd Floor, Fountains Health

Delamere Street

Chester

Tel: 01244 325721

MEDICAL PRACTICE

New Patient Health Questionnaire for Adults

Your Contact Details:

Title Surname

Date of Birth First Name

Occupation Previous Surnames

Home Address Ho Tel

Work Tel

Mobile

Email

Information about you

Which of the following best describes how you think of yourself?

Male Female Other

Are you a Military Veteran?

Yes No

Are you a student?

Yes No

What is your height?

What is your weight?

What is your first language?

Do you need an interpreter?

Previous GP

Name and address of previous GP

Medical Information

|  |  |
| --- | --- |
| Heart Disease | Hypertension Eczema |
| Diabetes | Cancer Stroke |
| Asthma | Epilepsy Blindness |
| Thyroid Problems | COPD Depression |

If yes, please state the year(s) when were you first diagnosed?

Please list any medicines being taken and the amount

Are you registered disabled? (if yes, please give details)

Yes No

Have you ever suffered from? (tick as appropriate)

Anxiety Yes No Depression Yes No

OCD Yes No Bipolar Disorder Yes No

If yes to any of these, please state the year(s) when where you first diagnosed?

Do you have any other mental health issues? (if yes please give details)

Are you receiving or have you received any treatment or therapy? (if yes please give details of your care and when you received it)

Carers

Do you have a carer? (if yes please give details)

Yes No

Are you a carer? (if yes please give details)

Yes No

Smoking

Do you smoke/vape?

Yes 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

Allergies

Are you allergic to anything? (if yes please give details) Yes No

Alcohol

1 drink = ½ 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?

Never Daily Weekly Monthly

WOMEN: How often do you have SIX or more drinks on one occasion?

Never Daily Weekly Monthly

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Daily Weekly Monthly

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Daily Weekly Monthly

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?

Yes No

Women

Have you ever had a cervical smear? (if yes. Please state when, where and the result)

Yes No

Do you have a coil or implant in situ? Yes No

Do you use any contraception? Yes No

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.

Next of Kin

Please give name, address, telephone number and relationship of next of kin

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? (if yes, enter date) Yes No Never



Have you had a pneumococcal vaccination? Yes No Never

Contacting You

I Agree that I may be contacted from time to time, via email and/or SMS, with practice news, advice about my health and/or appointment reminders. *(Please tick the box)*

Signature

Signature Date

*(You will be asked to sign this form when you visit the practice)*

National Data Sharing

**Please complete and/or tick the boxes below to detail your personal decisions regarding the aspects of NHS patient data sharing. It is very important you sign this form to say that you understand and accept the risk to your personal health care if you do decide to opt out of SCR. You will need to do this when you next visit the surgery.**

Is a summary of a patient’s sensitivities/allergies/current medication, which is uploaded to the national Spine. It can be accessed by any legitimate Clinician and is beneficial when a patient is seen at a hospital/ Out of Hours/Temporary resident at a GP practice. It is advisable to stay registered for this service.

Express consent for medication, allergies and adverse reactions online

Express consent for medication, allergies, adverse reactions and additional information

Express dissent – patient does not want a summary care record and fully understands the risk involved with this decision

Your data matters

From 25th May 2018 you can choose to stop your confidential patient information being used for purpose other then your care and treatment. This choice is known as national opt-out. If you have previously registered an opt-out with your GP Practice to request that NHS Digital does not use your confidential patient information, this will have automatically been converted to a national data opt-out on 25th May 2018. Or patients can view or change their national data opt-out choice at any time by using the online service at [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters).