**Dr William Littler**

**The Castle Surgery**

**NEW PATIENT HEALTH QUESTIONAIRE**

To register with our Practice please complete this questionnaire as fully as possible. The information will help the Doctor or Nurse to make an initial assessment of your health, which will help in your future treatment.

**TODAYS DATE: …………………………………**

**Name: …………………………………………… Date of Birth: …….………………………………..**

**Weight: ………………………………………….. Height: ………….…………………………………….**

**Date of last Tetanus: ………………………. Occupation: …………………………………………**

**Do you smoke? Yes / No If yes how many per day? …………………….**

**If you smoke how old were you when you started? ……………….**

**If you are an ex-smoker, how long ago did you stop? …………….**

**Do you take regular exercise? Yes / No**

**If yes, please state which type: ……………………………………………………………………………….**

**Current Medication: Please list any medication you take regularly. If you are taking repeat medication please make sure you have booked your new patient check appointment before your medication runs out.**

**Name of Medication: Strength: How many times a day:**

**…………………………………………. …………………………. ………………………………………….**

**………………………………………… …………………………. ………………………………………….**

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**…………………………………………. …………………………. ………………………………………….**

**Using the chart as a guide, please circle the appropriate answer to each question below.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | | | | | | **Your score** | |
| **0** | | **1** | | **2** | | **3** | | **4** | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily | |  | |
| **Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).** | | | | | | | | | | | | | |
| How often during the last year have you failed to do what was normally expected from you because of your 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 | |  | |
| 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 | |  | |

**Ladies only:**

**Contraceptive medication: ………………………………. Date of last smear: …………………………………………**

**IUCD (coil) currently fitted: yes / no Date fitted: …………………………………………………….**

**Date of hysterectomy: ………………………………………**

**Medical History:**

**Any allergies: ……………………………………………………………………………………………………………………………………………**

**Please list any important information regarding illnesses or operations you have had:**

**……………………………………………………………………………………………. Date: …………………………………………………..**

**……………………………………………………………………………………………. Date: …………………………………………………..**

**……………………………………………………………………………………………. Date: …………………………………………………..**

**Any Physical Disability: …………………………………………………………………………………………………….**

**Family History:**

**HEART DISEASE YES / NO Family member?………………………………………………..**

**(Heart attacks and Angina) Age when diagnosed………………………………………….**

**STROKE YES / NO Family member? ………………………………………………..**

**CANCER YES / NO Family member? …………………………………………………**

**Age when diagnosed…………………………………………..**

**Which type of cancer? ……………………………………………………………………………**

**CARERS:**

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

**Do you look after someone for his or her daily needs as a carer? YES / NO**

**(Excluding paid employment)**

**CONTACT DETAILS:**

**Please note that by providing us with the following details you are agreeing to be contacted by text or email as well as by telephone.**

**Home Telephone: ………………………………. Mobile: …………………………………………..**

**Work Telephone: ………………………………. Other: ……………………………………………..**

**Email: …………………………………………………………………………………………………………………………….**

**(Please write clearly).**

**You will automatically be given online access to book appointments, order your repeat prescriptions, view recent test results and your vaccination record. Access details will be emailed to you. (16 years and over).**

**Please tick the box if you do NOT want this access.**

**We share clinical data with other NHS organisations who only access it when needed, for instance if you visit Accident & Emergency. If you do NOT want us to share this information please tick the box.**

Please visit [www.hscic.gov.uk/scr/patients](http://www.hscic.gov.uk/scr/patients) for more information.

**Thank you for completing this questionnaire. We very much look forward to meeting you at your new patient check appointment. Please note that Dr William Littler will be your named accountable GP whilst registered at The Castle Surgery.**

**PATIENTS SIGNATURE……………………………………………. DATE…………………………………………**