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NEW PATIENT HEALTH CHECK FORM

As a new patient to our practice we invite you to attend a health check with our Practice Nurse. ***Please make an appointment with the receptionist***.

Date & time of appointment:

It would be helpful to us if you would kindly complete the following questionnaire and bring it with you when you attend your appointment. **PLEASE BRING A URINE SAMPLE**.

Surname:	**Forenames:**
Address: **Post Code:**	
Telephone No:	**Mobile Telephone No:**
Date of Birth:	**Occupation:**
E-Mail Address:	
Date of Registration:	**NHS No:**
Family Members at same address:	
Previous G.P. Name:	**Surgery Address:**

Have you had problems with any of the following? Please tick:

PERSONAL MEDICAL HISTORY ***(please tick appropriate boxes)***

Heart Disease		Digestive / Liver	
Chest / Asthma		Diabetes / Thyroid	
Kidney / Bladder		Gynaecological	
Stroke		Joints / Back	

Please give details of:

Operations:
Allergies:
Contraception:
Women} Cervical Smear. Date:

Vaccination Status	Tetanus: Date if known	Travel: Date if known

Please give details of Medication / Drugs: Prescribed and "over the counter" medicines or please bring your medication slip from your previous practice.

i)
ii)
iii)
iv)

FAMILY HISTORY
(Heart Disease, Stroke, High Blood Pressure, Asthma, Diabetes, Bowel Cancer, Other Cancers etc)

Grandparents:
Parents:
Brothers/Sisters:
Are they alive and well?

Do you have any communication needs or need to be given information in a certain way?

To be completed by the Practice Nurse:

Health Screen

Blood pressure:		Urine:	
Smoking:		Height:	
Weight:		Exercise:	
Diet:		Lipids:	
Blood Test (if required):		Alcohol: ***See Questions below***	
Self-examination:			

Questions	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	**1- 2**	**3 - 4**	**5 - 6**	**7 - 8**	**10 +**	
How often do you have 6 or more standard drinks on one occasion	**Never**	**Less Than Monthly**	**Monthly**	**Weekly**	**Daily or Almost Daily**	
Scoring: A total of 5+ indicates hazardous or harmful drinking						

FOLLOW UP:
PLANNING FUTURE USE OF SERVICE: