GRANGE PARK SURGERY
BURLEY IN WHARFEDALE

NEW PATIENT HEALTH QUESTIONNAIRE

NAME: ---------- D.O.B. ---------- OCCUPATION: ----------TEL: ----------

Please list any serious illnesses, operations and accidents you have had and any ongoing health problems:

Please list any medicines or tablets you take regularly:

Have you ever suffered any allergy to any medication:
Name of medication: **Type of reaction:**

Smoking status:

Never smoked ------

Ex-smoker ------ Smoked for -------- years Date stopped ----------

Current smoker: ---------- cigarettes per day
---------- cigars per day
---------- ounces of tobacco per day/week

Alcohol consumption: ---------- units per week
(1 unit = _ pint of beer or 1 small glass of wine or 1 measure of spirits)

HEIGHT ----------cms (measuring chart available in the waiting room)

WEIGHT ----------kgs (scales available in the waiting room)

WAIST CIRCUMFERENCE …….. For completion by the Practice Nurse

BLOOD PRESSURE ---------- For completion by the Practice Nurse

URINE DIPSTICK ---------- For completion by the Practice Nurse

continued overleaf

GRANGE PARK SURGERY
BURLEY IN WHARFEDALE

NEW PATIENT HEALTH QUESTIONNAIRE (continued)

Please tell us about the exercise you take and how often:

FAMILY HISTORY: Have any relatives had any of the following illnesses (please tick):

		Relationship to you (e.g. father, sister, etc.)
High Blood pressure	------	----------
Heart Attack	------	----------
Angina	------	----------
Stroke	------	----------
Diabetes	------	----------
Asthma	------	----------
Eczema	------	----------
Hay fever	------	----------
Epilepsy	------	----------
Glaucoma	------	----------
TB	------	----------
Cancer (please state type, e.g. bowel, etc.)	----------	----------

If your mother or father, or any brothers or sisters have died please tell us the cause of death and their age: Y/N

Have you been immunised against:	**YES (please tick)**	**YEAR**
Diphtheria	------	--------
Tetanus	------	--------
Polio	------	--------
Whooping cough	------	--------
Measles		
Mumps	------	--------
Rubella (German measles)	------	--------
BCG/TB	------	--------

FEMALE PATIENTS ONLY: Please tell us (if applicable):-

Number of Pregnancies -------- Number of children --------
Do you take the contraceptive pill? ------ Name of pill ----------
Do you have a coil fitted? ------
Date of your last cervical smear ---------- Normal Y/N
Date of your last mammogram ---------- Normal Y/N

ARE YOU A CARER? YES/ NO

(A carer is someone who looks after a relative or a friend who needs support because of physical or learning disabilities, mental illness, or whose health is impaired by sickness or old age. This includes parent carers of a disabled child and young carers under the age of 18)

If you wish to discuss any of the above you may do so during your consultation with the doctor or nurse.