

**Heathville Medical Practice**

**ADULTS NEW PATIENT HEALTH QUESTIONNAIRE**

To register with the Practice please complete this questionnaire as fully as possible. Please let us have this back prior to your New Patient Check appointment with the Practice Nurse. Your answers will be treated in the strictest confidence but will allow us to ensure continuity of health care until your medical records arrive from your previous surgery.

Full Name : ..... Date of Birth : .....






**YOUR HEALTH**

<b>Your Height :</b>		
<b>Your Weight :</b>		
<b>Do you suffer, or have you ever suffered, from any of the following conditions? <i>Please tick as appropriate</i></b>	<b>Yes</b>	<b>No</b>
Asthma/COPD		
Diabetes		
Epilepsy		
Thyroid problems		
Stroke		
Mental Health problems		
Heart Disease/Attack		
High Blood Pressure		
Cancer		
<b>Do you suffer from any of the following difficulties :</b>	<b>Yes</b>	<b>No</b>
Visual (i.e. registered blind)		
Hearing (i.e. wear hearing aid)		
Mobility (i.e. use walking sticks/wheelchair/housebound)		
Learning (i.e. have a permanent Carer)		
<b>ALLERGIES</b>	<b>Yes</b>	<b>No</b>
Do you suffer from any allergies?		
If yes, please indicate below what sort of allergy/allergies		
Drug Allergy (e.g. penicillin, aspirin, codeine)		
Nuts		
Animal hair		
Bee or Wasp stings		
Other, if yes, what?		
<b>QUESTIONS FOR WOMEN ONLY</b>	<b>Yes</b>	<b>No</b>
Have you ever had a smear?		
If yes, what was the date of your last smear?		
Do you have an IUCD (coil) fitted?		
If so, when was your last coil check?		
Have you had a hysterectomy?		
If so, what was the date?		

## LIFESTYLE

Please complete the following sections about your lifestyle. Your answers will help us to provide you with the most appropriate advice and ongoing health care.

### ALCOHOL CONSUMPTION

<b>Drinks</b>					
<b>Units</b>	Pint of Regular Beer/Lager/Cider <b>2 UNITS</b>	Alcopop or Can of Lager <b>1.5 UNITS</b>	Glass of Wine (175 mls) <b>2 UNITS</b>	Single Measure of Spirits <b>1 UNIT</b>	Bottle of Wine <b>9 UNITS</b>

Questions	0	1	2	3	4
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
How many units 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 units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

### SMOKING

**I have never smoked**

**I used to smoke** ..... Cigarettes / Cigars a day ..... oz. pipe tobacco a day  
Date started ..... Date stopped .....

**I currently smoke** ..... Cigarettes / Cigars a day ..... oz. pipe tobacco a day  
Date started .....

**Passive Smoking** Does anyone in your home or at your place of work smoke? **YES / NO**

**Giving up Smoking will greatly benefit your health - our Practice Nurses are all fully trained Smoking Cessation Advisers. Please tick here if you would like to give up smoking and will be happy to see a Practice Nurse for advice.**

### EXERCISE

	Yes	No
<b>Do you take regular exercise?</b>		
<b>If yes, is the exercise</b>		
Light?		
Moderate?		
Heavy?		
<b>Is your work physically strenuous?</b>		

**Thank you for this information. Please return the form to the Practice before your New Patient appointment. When you attend for your appointment, please bring a sample of urine with you – bottles are available at the Reception Desk.**