New Patient Health Questionnaire for Adults

Personal Details

Title:…….. First names:…… Surname:……

Date of Birth:……. Occupation:……

Home Address: Home Tel:……

…… Work Tel:……

…… Mobile:……

……

…… Email:……

Postcode:……

First Language:…….. Ethnicity:……

Previous GP (Name and Address):……

……

……

Medical Information

Weight:……..kg Height:……..m

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place:

Have you ever suffered from? (please tick and specify year of diagnosis if known)

Epilepsy	☐	**Blindness/Glaucoma**	☐	**High Blood Pressure**	☐
Diabetes	☐	**Heart Attack**	☐	**Stroke/TIA**	☐
Depression	☐	**Cancer**	☐	**Asthma**	☐
COPD	☐	**Eczema/Hay Fever**	☐		

Please list any medications taken and the amount

Are you registered disabled? Yes ☐ No ☐

Please give detail:……

……

Are you allergic to any medicines, and if so which? Yes ☐ No ☐

Have you ever refused treatment/screening of any kind, and if so, what and when? Yes ☐ No ☐

Have you ever suffered from? (please tick and specify year of diagnosis if known)

Depression ☐ **Anxiety** ☐ **OCD** ☐

Bipolar disorder ☐ **Other (Please specify)** ☐ **……**

……..

Are you receiving or have you received any treatment or therapy? (If yes please give details of care and when this occurred)

Smoking

Do you smoke? Yes ☐ No ☐

If 'No' have you ever smoked? Yes ☐ No ☐ If 'Yes', when did you quit?.....

If 'Yes' how many cigarettes/ounces of tobacco do you smoke each day? ……..

Would you like advice on giving up smoking? Yes ☐ No ☐

Alcohol

1 drink = ½ piny of beer or 1 glass of wine or 1 single unit of spirits

MEN how often do you have EIGHT or more drinks on one occasion?

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

Never ☐ Less than monthly ☐ Weekly ☐ 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 ☐ Weekly ☐ Daily ☐

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

Never ☐ Less than monthly ☐ Weekly ☐ Daily ☐

In the last year has a relative/friend/doctor/health worker been concerned about your drinking and suggested you cut down?

No ☐ Yes, on one occasion ☐ Yes, more than once ☐

What is your weekly alcohol consumption? ……units/week

Carers

Do you have a carer? Yes ☐ No ☐ If yes please give details:……..
……..

Are you a carer? Yes ☐ No ☐ If yes please give details:……..
……..

Will

Do you hold a Living Will? Yes ☐ No ☐

(*A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)*

Women

Have you ever had a cervical smear? Yes ☐ No ☐

If yes please state when, where and result:
