BROOM ROAD MEDICAL PRACTICE
REGISTRATION - PATIENT HEALTH QUESTIONNAIRE (ADULT – 16yrs and over)

Welcome to the Broom Road Medical Practice. As you are a newly registered patient we would like to invite you to attend a Health Check with our Practice Nurse. As part of the process we need you to complete the following questionnaire.
This information will be important in helping us to provide you with good medical care.
Please return this form with your Registration Forms and make an appointment with the Receptionist for a 'New Patient Health Check'

REGISTRATION AND FAMILY DETAILS

Surname ……………………………………......……………

Forenames ……………………………………...........………………....

NHS No: ……………………………………………………

Previous Surname(s) (if any) ……………………………………………....

Title (Mr., Mrs., Miss, Mx etc.) ……………………......……………

Date of Birth ……………………………………………………………….

Gender ……………………………………………………..

Place of Birth ….........……………………………………………………

Marital Status
☐ Single
☐ Married
☐ Living with Partner
☐ Separated
☐ Divorced
☐ Widowed

Address ……………………………………………............……………
……………………….............…………………………………......

Post Code ……………………………………....……………....

Telephone Number **Home**……………………………………………..

Telephone Number **Mobile**… ………………………………………….

Email Address: ……………………………………………………….....

Is English your main language? **Yes/ No**

If No what is your main language? ………………………

Do you need interpreter? **Yes/ No**

Do you have Children? **Yes/ No** (If Yes how many) ………

Your Occupation ………………………………………............

*** Name Next of Kin :** Mr/ Mrs/ Miss/ Ms**……………………………. *Relationship to Patient ……………………………….**

(**Title, First name, Surname**)

Tel no Next of Kin **Home ………...….....…………….**

*Tel no Next of Kin **Mobile ………………………………………**

***Next of Kin Address: ………...**

***Are you happy for us to discuss your health conditions with your next of kin? Yes/ No** (Please circle the answer)
***Emergency Contact: Yes/ No** (Please circle the answer)

Ethnic Groups (please tick one option and delete as appropriate)

☐ White – British/Irish/Other – please specify what country and when you entered the UK…...……………………………………

☐ Black – Caribbean/African/Other – please specify ………………………………………………………….……………………..

☐ Asian – Indian/Pakistani/Chinese/Other – please specify ……………………………………….……………………………..

☐ Mixed – White & Black Caribbean/White & Black African/White & Asian/Other mixed – please specify ……………………..…

Proof of Identity and address provided?

☐ Birth Certificate ☐ Driving Licence ☐ Passport ☐ Utility Bill ☐ Allowance Book ☐ Solicitor's letter

☐ Offer of Tenancy ☐ Other Proof: ……………………………………………………………………………….…………

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

……

Please list any medicines being taken and the amount:

……

Are you allergic to any medicines, or do you have any known allergies, if so please state………………………………………

Your Weight:	**Your Height:**
Do you smoke? YES ☐ NO ☐ If "yes" how many cigarettes/cigars per day? If "no", have you ever smoked and when did you gave up?	**How much alcohol do you drink in a week? …………….. units.** (1 unit = ½ pint beer, 1 small glass of wine, 1 single spirit, 1 small glass of sherry.)
Do you take any exercise? YES ☐ NO ☐	If "yes" how often: 1 time/week ☐ 2 times/week ☐

	3+times/week☐ or takes inadequate exercises ☐

Are you registered disabled? Yes/No If yes, please give details of your disability ………………………………………………….
………..
Do you have a carer? Yes/No
If yes, please give details of your carer (Name, Contact Number Home & Mobile) ……………………………………………………..
……….
Are you a carer? Yes/No If yes, please give details of who you care for (Name, relationship) …………………….…
……….

Have you been immunized against: (Please tick those which apply)

☐ Diphtheria ☐ Polio ☐ Measles ☐ Mumps ☐ Rubella (German Measles) ☐ Whooping Cough ☐ BCG

Family History

Please state any serious illness, in particular cancer, heart disease, strokes, high blood pressure diabetes or any inherited disease. If deceased please state age and cause of death:

Father………

Mother……

Have you any Brothers or Sisters? Yes / No
If Yes what is their present health status………………………………………………………………………………………

Have any of your relations had any of the following (Please tick as appropriate)

☐T.B. ☐ Diabetes ☐ High Blood ☐ Pressure ☐ Heart Attack ☐ Depression ☐ Asthma ☐ Eczema ☐ Hay Fever ☐ Migrane ☐ Stroke ☐ Cancer ☐ Epilepsy ☐ Glaucoma ☐ Thrombosis ☐ Thyroid Disorder ☐ Stomach Ulcers

Any other inherited disease? Yes/ No If Yes please give details…………………………………………………………………..

For Patients aged 65 and over or those with a Chronic Disease (e.g. asthma, diabetes etc.)

Have you had a 'flu vaccination? Please enter date or 'never' ……………………………………………………………………...

Have you had a pneumococcal vaccination? Please enter date or 'never' ………………………………………………………

Please indicate if you **do not** wish to have a { 'flu vaccination by ticking here ☐ / a pneumococcal vaccination by ticking here ☐ }

Are you a carer for someone?	**Yes** ☐ **No** ☐ **If yes (who for?)** ………………………….

For Women

Are you rubella immune (German measles) Yes/No

Do you want contraceptive care? Yes/No

Are you taking the oral contraceptive? Yes/No

Are you fitted with a coil? Yes/No If Yes, when was your last coil check? ………………………………………………………………

Have you had a cervical smear? Please enter year or 'never' …………………………………………………………………….

Have you had a hysterectomy? Yes/No
(Please note that unless you have had a hysterectomy it is strongly advised that you have regular smears. You will automatically receive reminders at the currently recommended interval.

Signed ……………………………………………………………………….. Date …………………………………………………

I consent to the NHS Spine sharing my details with NHS Organisations for the benefit of my health care. Yes ☐ No☐