**CORBRIDGE MEDICAL GROUP**

**CONFIDENTIAL HEALTH QUESTIONNAIRE**

**FOR NEW PATIENTS**

Welcome to the practice. It can take a number of weeks for your medical records to arrive from your previous practice and, in order to facilitate a smooth transition in your medical care, we would be grateful if you would complete the enclosed questionnaire and hand it into Reception with the Registration Form.

This is particularly important if you are currently in receipt of any repeat medication as we will need to ensure that we have all the appropriate information and/or blood tests required to accurately prescribe for you.

You may be invited to attend for a new patient check appointment which lasts around 20minutes and involves a brief review of your medical history, height, weight and blood pressure monitoring as well as an assessment of any regular screening or annual recalls you may require.

We thank you for your assistance.

**Personal Details**

|  |  |
| --- | --- |
| Surname | First Names |
| Address | Post Code |
| Tel. No | Date of Birth | Marital Status |
| Occupation | Occupation of Partner |

Do you live with your family at the above address Yes / No

Do you live with other people to whom you are not related Yes / No

Do you look after any relatives not living with you Yes / No

Do you act as the main carer for another member of the household (excluding your children) Yes / No

Would you consider yourself to be housebound Yes / No

Have you ever served in the armed forces? Yes / No

Have you ever lived abroad Yes / No

**Your Health**

What is your height ............................................... your weight....................................

Have you ever suffered from any of the following conditions:- (Please tick as appropriate)

Asthma/COPD ( ) Diabetes ( ) Stroke ( ) High Blood Pressure ( ) Heart Attack/Angina ( ) Epilepsy ( ) Blackouts/Faints ( ) Thyroid Problems ( ) Nervous/ Mental Breakdown ( ) Cancer ( )

Have your parents or brothers and sisters suffered from any of the above, or an inherited disease Yes / No

If 'Yes', please state their relationship to you and the condition.

Please give details and approximate dates of any significant illnesses, disability or operations you have had.

Are you currently taking any tablets, medicines or injections? Yes / No
**If 'Yes', please list these below with the doses if known or attach a copy of the re-order slip from your last prescription.**

Have you any allergies to medicines or to anything else? Yes / No
If 'Yes', please give details

**Lifestyle** Please tick the appropriate answers

**Smoking**

( ) I have never smoked

( ) I used to but gave up in ......................(date)

( ) I currently smoke .......... cigarettes / cigars .......... oz. of pipe tobacco per day

**We would like to emphasise that smoking is one of the biggest preventable causes of ill-health in the country and as such we would like to offer support and encouragement to help you to stop smoking. Many people manage to stop smoking alone but quit rates are higher in those who have help and we recommend the following websites as a great starting point.** [**www.smokefree.nhs.uk**](http://www.smokefree.nhs.uk/) **:** [**www.nosmokingday.org.uk**](http://www.nosmokingday.org.uk/) **:** [**www.nhs.uk/livewell/smoking**](http://www.nhs.uk/livewell/smoking)

|  |  |  |
| --- | --- | --- |
| **Drinking** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Total score |  |

**Exercise**

( ) I do take regular exercise

( ) I do not take regular exercise

**THANK YOU FOR COMPLETING THIS FORM**