New Patient Health Questionnaire

Over 16's

Towcester Medical Centre

Personal Information		
Your Full Name		
Home / Mobile Phone Numbers	**Home:**	**Mobile:**
E-Mail Address		
Ethnic Origin		
First Language		
Do you need an interpreter?	**YES / NO**	
Do you have someone who looks after you?	**YES / NO**	**If YES please tell us who looks after you**
Do you look after someone elderly or disabled?	**YES / NO**	**If YES please tell us who you look after**

Prescriptions		
If you are currently on any repeat medication please tick this box. It would be helpful if you could provide us with a **repeat prescription slip** or a **note from your previous GP.**		
Would you like us to send your prescription electronically to a local pharmacy?		**YES / NO**
If YES please indicate which pharmacy you would like.	**LLOYDS - BROOK HEALTH CENTRE** (next door)	
	LLOYDS - WATLING STREET (town centre)	
	OTHER (please specify)	
If you live **more than <u>one mile</u> from a pharmacy** and would like to have your medications dispensed at our **Paulerpsury Surgery** tick here.		
On-Line Patient Access		
On line access for booking appointments and ordering medication is available to **ALL** patients. Would you like on-line access?		**YES / NO**
SMS Contact		
Please indicate whether you consent to being contacted via SMS text message with appointment and health reminders and news about the practice.		**YES / NO**
Summary Care Record		
Can we give a Summary Care Record to other healthcare providers if needed? *A **Summary Care Record is a** copy of key information from your record. It gives authorised healthcare staff faster, secure access to essential data when you need unplanned care or when we're closed.*		**YES / NO**

Social Services		
Has a Social Worker ever been involved with you / your family?	**YES / NO**	**If YES please give further details**
Medical Conditions & Allergies		
Please tell us about any medical condition that we need to know about before your medical notes come through, including any allergies that you are aware of.		
MEDICAL CONDITION		
ALLERGY		
Patient Information		
On registration you will be allocated a named GP but you are free to make an appointment with any GP at the practice. If you wish to know who your named GP is please contact the surgery.		
Overleaf there are some questions about your family medical history and lifestyle. Your answers will help us understand your circumstances & how we can help maintain and improve your health.		

Alcohol

How often do you drink alcohol?	**NEVER**	**MONTHLY OR LESS**	**2 - 4 TIMES A MONTH**	**2 - 3 TIMES A WEEK**	**4+ TIMES A WEEK**
How many standard alcholic drinks do you have on a typical day?	**1 - 2**	**3 - 4**	**5 - 6**	**7 - 8**	**10+**
How often do you have 6 or more drinks on one occasion?	**NEVER**	**MONTHLY OR LESS**	**MONTHLY**	**WEEKLY**	**DAILY OR ALMOST DAILY**

Physical Activity

On average how often do you engage in physical activity like a brisk walk?	**NEVER**	**MONTHLY OR LESS**	**2 - 4 TIMES A MONTH**	**2 - 3 TIMES A WEEK**	**4+ TIMES A WEEK**
On average how many minutes do you engage in this activity?	**05 - 10 MINS**	**10 - 20 MINS**	**20 - 30 MINS**	**30 - 60 MINS**	**60+ MINS**

Smoking

Have you ever smoked?	**YES / NO**
If YES how many per day?	
Have you given up smoking?	**YES / NO**
If YES when did you give up?	
If NO would you like support from us to help you give up?	**YES / NO**

Body Mass Index

Please tell us roughly your height	
Please tell us roughly your weight	

Family History

Has anyone in your family had any of the following medical conditions?	**WHO?**	**AGE?** when diagnosed
ASTHMA		
DIABETES		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
HEART ATTACK		
STROKE		
CANCER		
EPILEPSY		
MENTAL HEALTH (ANXIETY / DEPRESSION)		

THANK YOU FOR COMPLETING THIS FORM

The information given will be treated confidentially and will form part of your medical record.
This practice is registererd under the Data Protection Act.