Heaton Medical Centre

www.boltongp.co.uk

New Patient Health Questionnaire

Please complete as many questions as you can. The information will help the practice to provide better medical care for you. This information will be held in the strictest confidence as per Data Protection Law.

Forename:	Surname:

Address: Postcode:	Date of Birth:
	Home Tel:
	Mobile Tel: **This number will be used for text messages**
	Work Tel:
	Nominated Pharmacy:

Medical Information

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

Have you been diagnosed with ? (**tick and date below)**			
Epilepsy	☐ ___/__ /___	Blindness/Glaucoma	☐ ___/__ /___
High Blood pressure	☐ ___/__ /___	Diabetes	☐ ___/__ /___
Heart Attack/Stroke	☐ ___/__ /___	Depression	☐ ___/__ /___
Cancer	☐ ___/__ /___	Asthma	☐ ___/__ /___
Eczema/Hay fever	☐ ___/__ /___	COPD	☐ ___/__ /___

Please list any medicines being taken and the amount: (use extra paper if required)
Please bring in your full list of medication either from your previous gp surgery or bring in your repeat side of your last prescription!
Are you allergic to any medicines and if so, which?

Are you registered disabled? (if yes please give details)

Do you have a carer? (if yes please give details)
Are you a carer? (if yes please give details)

Are you a military veteran? (if yes please give details)

Smoking status	☐Current Smoker ☐Never Smoked ☐Ex-smoker
If you currently smoke, how many cigarettes or ounces of tobacco per day?	
Would you like any advice on giving up?	

Alcohol
1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit
How many units per week do you drink? _____
Height: _____
Weight: _____

Family History Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease (mother/father/brother/sister).

Have you ever had a cervical smear? (if yes please state when and where)

For patient aged 65 and over Please give names, address and telephone number of **next of kin**
Have you had a flu vaccination? (enter date or `never`) _____ Have you had a Pneumococcal vaccination? (enter date of `never`) _____

Ethnic Group			
White	British ☐ Irish ☐ Other _____		
Black	Caribbean ☐ African ☐ Other _____		
Asian	Indian ☐ Pakistan ☐ Chinese ☐ Other _____		
Mixed	White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Other _____		
Language		Gender	Male ☐ Female ☐

Which of the following options best describes how you think of yourself?	
Woman (including trans woman)	
Man (including trans man)	
Non-binary	
In another way (please state)	

Which of the following options best describes how you think of yourself?	
Heterosexual	
Bisexual	
Gay or Lesbian	
In another way (please state)	

Summary Care Record:

I have read the information supplied ☐

I wish to have an NHS Summary Care Record for allergies, medications and adverse reactions ONLY ☐

I wish to have an NHS Summary Care Record for allergies, medications Adverse reaction AND additional information. ☐

I decline to have an NHS Summary Care Record ☐

Text Message:

I consent to receiving text messages for appointments/reviews/immunisations ☐

I DO NOT consent to receiving text messages ☐

We are part of the Bolton Care Record. Records that your GP holds about you will be able to be shared with relevant NHS Healthcare and Social care professionals.

By signing this form, you agree to treat the doctors and staff with courtesy and respect, and if there is a breakdown of patient doctor relationship, you could be removed from the practice list:

Signature _____ Date _____