CONFIDENTIAL - HEALTH QUESTIONNAIRE FOR NEW PATIENTS

Patient Number: _____

Personal Details

Family Name :

First Name :

Date of Birth:

Previous Family Name:

Calling Name:

Address :

Post Code :

Telephone No. : Home
Work
Mobile

Email Address :

Personal Status: Single ☐ Married ☐
Separated ☐ Divorced ☐
Widowed ☐ Co-habiting ☐
Civil partnership ☐

Place of Birth: _____ _____

Date of arrival into UK: __ _____

Occupation: _____

Nationality: _____

Next of kin: _____ **Tel:** _____

General needs

Do you need support with spoken English? NO ☐ YES ☐

Interpreter requried ☐ Language: _____
Sign language ☐
Hearing aid ☐

Do you consider yourself to have a disability? NO ☐ YES ☐

(Please specify) ___ _____

Do you help and support someone on regular basis? NO ☐ YES ☐

>75 or diabetic? ☐

Does anyone help and support you on regular basis? NO ☐ YES ☐

Are you any of the following?

HOMELESS ☐ REFUGEE ☐ ASYLUM SEEKER ☐ CARER ☐

Ethnic Origin

BLACK or BLACK BRITISH
Caribbean ☐
African ☐
Any other Black background ☐ _____

MIXED
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other mixed background ☐ _____

WHITE
British ☐
Irish ☐
Any other white background ☐ _____

ASIAN or ASIAN BRITISH
Indian ☐
Pakistani ☐
Bangladeshi ☐
Any other Asian background ☐ _____

CHINESE or OTHER ETHNIC GROUP
Chinese ☐
Vietnamese ☐
Any other ethnic group ☐ _____

I DO NOT WISH TO STATE MY ETHNIC GROUP ☐

MAIN SPOKEN LANGUAGE _____

Present and Past Illnesses

		Dates / Details
Have you got any current or past medical problems? past medical problems ?	Yes ☐ No ☐	
Have you had any hospital treatment or operations?	Yes ☐ No ☐	
Have you ever had any significant psychological probolems or st problems or stress?	Yes ☐ No ☐	
Do you suffer from Asthma, Eczema, Hayfever or other alergies' other allergies?	Yes ☐ No ☐	
Are you taking any regular medication - including the contaceptive pill?	Yes ☐ No ☐	**Name and dose of medication**
Are you allergic to any medication?	Yes ☐ No ☐	

If you do not want to share all or part of your record you need to tell your GP or health care assistand during your initial Health Check.
They can mark specific parts of your record as private. Information marked as private will not be shared outside that organisation
Patient information leaflets available at the reception.

Family Medical History

	Age / Date of birth	State of Health	If died, age at death	Cause of death
Father:				
Mother:				
Brothers:				
Sisters:				

Immunisation

Please give details and date of the following if known:

Polio Immunisation Date : Tetanus Immunisation Date :

Foreign Travel Vaccines

Typhoid Date :
Yellow Fever Date :
Havrix (Hepatites A) Date :

Rubella blood test (to check immunity to German Measles)
Year : Result :

Women Only

Date of last cervical smear :
Result :
Performed by : GPAbroad PrivateOther

Next smear due :

Date of last mammogram :
Result : GPAbroad PrivateOther

Contraception method :

BMI- Body Mass Index

Height : Weight:

Life Style -We provide a stop smoking clinic for registered patients.

Smoking

Do you smoke NoCigars / PipesNo. per day

Are you an ex-smoker No

Do you take regular exercise? Yes Detail : No

Drinking

In the last three months, on average how many drink, days per week have you had an alcoholic drink ?

Number of days per week

On average, on a day when you have had an alcoholic drink, how much have you usually had ?

Half pints of beer, lager, cider (if you usually drink pints, calculate in halfs)

Glasses of wine, sherry, vermouth

Single measures of spirits (e.g. gin, vodka, rum, brandy, whiskey)

We are pleased to have you as a new patient here at Scarsdale. We do ask if you could kindly be patient with us while we retrieve your old mediacal records (this may take up to 4 weeks) please come prepared for your health check with the nurse who will ask for a detailed Past Medical nad Surgical History and current medication (it would be helpful if you could bring any current medication with you)

If you would like to join our Patient Participation Group please let us know

Patients Signature : Date :