NHS
Nottingham West
Clinical Commissioning Group

Saxon Cross Surgery
New Patient Health Questionnaire
PLEASE COMPLETE ALL SECTIONS

First Name(s) **Surname**

Title: Mrs Ms Mr Other: (please indicate) **Date of Birth**

What is your height ? **cm**

What is your weight? **Kg**

Have you ever been diagnosed with any of the following medical conditions?

Arthritis Yes/No	Asthma Yes/No	Cancer Yes/No
Chronic Bronchitis Yes/No	Depression Yes/No Anxiety Yes/No Bipolar Disorder Yes/No OCD Yes/No	Heart attack/angina Yes/No
Diabetes Yes/No	Epilepsy Yes/No	High blood pressure Yes/No
Thyroid trouble Yes/No	Tuberculosis Yes/No	Ulcer (duodenal/gastric) Yes/No
Stroke Yes/No		

Have you ever had any other illnesses, accidents or operations Yes/No
If yes please give details:

Are you currently under the care of a hospital specialist Yes/No
If yes please give details:

Please give full details of any medicines or tablets you are currently taking:
(A copy of your latest repeat prescription list would be helpful)

Are you allergic to any medicines or tablets **Yes/No**

If yes please give details:

Smoking :

Do you Smoke? **Yes/No**

If no, have you ever smoked? **Yes/No**

If you currently smoke, how many cigarettes or ounces of tobacco do you smoke per day?

Cigarettes/Ounces of tobacco

If you've stopped, how many did you use to smoke and when did you stop?

If you smoke would you like to receive advice on giving up? **Yes/No**

Alcohol :

Do you drink alcohol? **Yes/No**

If you currently drink, how many units do you drink per day?
(1 unit = ½ pint of beer or 1 small glass of wine or 1 single measure of spirit)

Units per day

If you answered no, did you use to drink? **Yes/No**

If you used to drink, how many units per day did you drink?

Units per day **Date stopped**

Would you like advice on cutting down?
Yes/No

LivingWill :

Do you hold a living will? **Yes/No**

(A living will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

Vaccination: (over 65's or those in an 'at risk group)

Have you ever had a flu vaccination : enter latest date or never

Have you ever had a pneumococcal vaccination: enter latest date or never

Female Patients only:

Have you ever had a cervical smear **Yes/No**

If yes, please state when, where, and the latest result

THANK YOU FOR PROVIDING THE INFORMATION