WEST QUAY MEDICAL CENTRE
New Patient Health Questionnaire

Dear Patient

As a newly registered patient of West Quay Medical Centre, we would be grateful if you could complete this questionnaire. This will allow us to provide you with excellent medical care.

If you have any questions regarding this questionnaire of any other matter, please speak with a receptionist, they will be happy to answer you queries.

ALL INFORMATION THAT YOU GIVE IS COMPLETELY CONFIDENTIAL

PERSONAL INFORMATION

Please tick relevant box

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname: …… Gender: Male / Female

Forename(s): …… Date of Birth: ……../……/……

Address: ……

……..

……..

Post code: ……

Home Tel: ……

Mobile Tel: ……

Work Tel: ……

Email Address (optional): ……..……

Marital Status: Please tick relevant box

Married / Living with Partner ☐ Single ☐ Divorced / Separated ☐ Widowed ☐

Next of Kin:

Name: …… Relationship: ……

Contact Tel No.: ……..

DISABILITY ACCESS NEEDS/SENSORY LOSS/CARER

1. Do you consider yourself to have a disability Yes ☐ No ☐

2. If yes, please specify the nature of the disability

……

3. Is there any other information relating to your disability that the Practice needs to be aware of?
   i.e. Wheelchair use, Use of walking aid, Need to attend with care / helper etc

……

……

……

4. Do you suffer with Sensory Loss? Yes ☐ No ☐
5. If yes, please specify what you require support with (Hearing Loss/Visual Impairment/Speech/Language Difficulties)

   ……
6. Please specify which Language you prefer to be communicated in ……..
7. Are you a carer? Yes ☐ No ☐
8. If yes, is the person you care for our patient? Yes ☐ No ☐

   Patient Details: ……
   Name DOB Adddress etc

VETERANS

1. Do you/Have you ever served in the Armed Forces? Yes ☐ No ☐
   (Office use only – If Yes Please read-code 13q3)

MEDICAL INFORMATION

Have you ever suffered from the following illnesses?

ILLNESS	YES	NO	DATE OF DIAGNOSIS
Diabetes			
High Blood Pressure			
Coronary Heart Disease			
Asthma			
Chronic Bronchitis			

Epilepsy			
Cancer			
Thyroid Disease			
Severe Mental Health Disorder			
Kidney Disease			
Atrial Fibrillation			

Have any close relatives had heart disease or stroke before aged 55 years?

Yes ☐ No ☐ If yes please provide details: …….

……..

When was your blood pressure checked? …….

Women Only: The date of your last smear? …….

Are you on medication and / or receiving any treatment at present for any medical condition?

Yes ☐ No ☐ Please Provide Details:

…….

…….

Current Weight: ……. Height: ……...

Do You Smoke? Yes ☐ No ☐ Ex ☐

If yes how many per day? ……

If ex-smoker – when did you stop smoking? ……..

Would you like to receive smoking cessation information? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐

If yes, how many units per week? Beer ☐ Wine ☐ Spirits ☐