**BRIDGE STREET FAMILY PRACTICE**

**NEW PATIENT HEALTH QUESTIONNAIRE**

**Please read this document carefully:**

**INTRODUCTION - please complete ALL of this questionnaire.**

This questionnaire will help to establish a base-line view of the patient life-style and will assist the nurse / doctor in carrying out a new patient health check.

The information provided will assist also in the identification of "at risk" patients and focus care advice on at risk areas. Please remember to bring a urine sample to your appointment.

**(Patients coming from the South of Ireland, eligible to register in N.Ireland will be asked to produce a copy of your medical record from your previous GP in Southern Ireland. If you are taking medication you must produce a printed computer record of your drug record from your previous GP in Ireland failure to do so could delay your treatment)**

## Date of Completion: _____

**To the Patient…**

*Please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. All information is treated with confidentiality under the Data Protection Act.*

**Patient Name: ..... Date of Birth: .....**

**Address: .....**

**.....**

**Post Code: ..... Occupation: .....**

**Home Telephone No: Mobile No: Work No:**

**Name of Next of Kin: .....**

**Relationship to you: .....** (spouse, parent, sibling etc.)

**Their Home Telephone No:** ..... **Mobile Telephone No:** .....

**HOW DID YOU HEAR ABOUT THIS PRACTICE?**

**……..**

**PLEASE ENSURE YOU LIST ALL YOUR ALLERGIES.**

**Any Allergies to medication** : please list the drug/medication you are allergic to

_____

_____

## Any other type of allergies? if so please list -:

**BMI**

**Weight**_____**Height**_____

**Urine** _____ **BP** _____

**MEDICATION**

**Are you taking any medication at present? (please list the name of your medication, dose and how often you take it)**

**.....** **.....**

**.....** **.....**

**.....** **.....**

**.....** **.....**

**MEDICAL HISTORY ( Conditions) please list: if you know the date of the onset of your medical condition please state the date**

**Blood pressure checked in the last 10 years?** **Yes / No**
**Tetanus jab in the last 10 years?** **Yes / No**
**Cholesterol checked in the last 2 years?** **Yes / No**

**Any other vaccinations in the last year? (e.g. Flu vaccination) if yes please state:**

**.....**

**LIFESTYLE:**

**SMOKING.**

Do you smoke? Yes / No. If Yes, how many per day?_____

If you smoke, how old were you when you started?_____

**EX-SMOKERS.**

If you are an ex-smoker but have not stopped, how old were you when you stopped?_____

If you did smoke in the past , how many did you smoke per day?_____

**PASSIVE SMOKING**
Are you exposed to smoke at work? Yes / No. At home? Yes / No

**ALCOHOL.**

How many units of alcohol do you drink each week?_____
*(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)*

**DIET & EXERCISE**

Do you add salt to your food during or after cooking? Yes / No
Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No
Are you a vegetarian? Yes/No

**EXERCISE**
What form of exercise do you take? (e.g. walking, the gym etc.) _____
How many minutes do your exercise for at a time?_____ How many times per week?___

**FAMILY HISTORY**

Are any of your family registered at this practice? Please give their names. **Yes / No**

**Name _____**

**_____**

Is there a family history of any of the following illnesses? *(father, mother, brother, sister)* **before age of 65?**

Heart Disease (Heart attacks, angina) Yes / No. Which family member?_____
Stroke? Yes / No. Which family member?_____
Cancer? Yes / No. Which family member?_____
Site of cancer?_____

**CARERS**

Do you need / have anyone you looks after you or your daily needs as Carer? Yes / No

If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)

Do you care for anyone else? Yes / No

If "Yes", ask the receptionist about Carers support

**Any additional Information**

**<u>Please note</u>: If you are taking any of the following medications – Diazepam, Zopiclone, Zimovane or Temazepam, it is the policy of this practice to manage all patients on a gradual reducing dose as these drugs are very addictive and all new patients on these drugs will be issued with them but you must sign up to a dose reduction management programme.**
**By signing this new patient registration form indicates you are signing and agreeing to this policy.**

**<u>This will be a gradual reduction and you will need to see the doctor for your first prescription</u>.**

**If you are currently on medication and on repeat prescriptions, you should obtain a prescription for all medications from your previous GP until such times as you see a doctor within this practice.**

**Signature of Patient**: .....

**Date:** .....

*Thank you for completing this questionnaire. You will be invited for an initial examination, discussion about your health, and general check within the next few weeks by our Health Care Assistant.*
*If you are concerned about your Health please inform the Healthcare Assistant.*

***Notes made by the Healthcare Assistant/Nurse (if no notes please sign as the person entering the computer data)***

***signed:* ..... *date:* .....**

***<u>ETHNIC ORIGIN</u>*:** we are asked by the Dept of Health to obtain this information. You do not have to supply this information but should you choose not to do so, an ethnic coding will be assigned to your computer record.

**How would you best describe your Ethnic Origin? e.g white British, white Irish, Indian, other Asian background etc : .....**