

THE RED HOUSE GROUP OF PRACTICES

124 Watling Street, Radlett, Hertfordshire, WD7 7JQ

Tel: 01923 855606 Fax: 01923 853577

QUESTIONNAIRE

FOR YOUR

NEW PATIENT HEALTH CHECK

THANK YOU FOR YOUR CO-OPERATION!

Compiled K. McCarthy, Health Care Assistant, 2005

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YOUR DETAILS

NAME:

ADDRESS:

POST CODE:

DATE OF BIRTH:

ETHNIC ORIGIN:

CONTACT TELEPHONE NUMBER:

MOBILE NUMBER:

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**NEXT OF KIN**

**NAME:**

**ADDRESS:**

**CONTACT TELEPHONE NUMBER:**

**RELATIONSHIP TO YOU:**

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**YOUR MEDICAL HISTORY**

**When you come to see the Nurse/Health Care Assistant for your appointment, please have the following information:**

- **What childhood immunisations have you had? Include dates wherever possible.**
- **What vaccinations have you had recently for travel abroad/work etc? Include dates wherever possible.**
- **Have you ever had a Pneumovax injection for pneumonia?**
- **Do you have FLU vaccinations every year?**
- **What were the reasons for any recent visits to hospital?**

• **What medication are you taking at the moment?**  
**Please include ‘over the counter’ medication, inhalers, creams and contraceptives**

| <u>Name</u>      | <u>Type</u> | <u>Strength</u> | <u>Amount Taken Per Day</u> |
|------------------|-------------|-----------------|-----------------------------|
| e.g. SIMVASTATIN | TABLETS     | 40MG            | 1 TABLET TWICE A DAY        |

1.

2.

3.

4.

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- **Do you have any significant health problems at the moment?  
e.g. diabetes, high cholesterol, heart disease, high blood pressure.**

| <b>PAST ILLNESSES/<br/>OPERATIONS</b> | <b>WHEN?</b> | <b>IS THIS STILL AN ISSUE?</b> |
|---------------------------------------|--------------|--------------------------------|
|                                       |              |                                |
|                                       |              |                                |
|                                       |              |                                |
|                                       |              |                                |
|                                       |              |                                |
|                                       |              |                                |

- **FOR WOMEN:**

When did you have your last smear and what was the result?

If you are taking the contraceptive pill, when did you last have your blood pressure taken? Was it normal?

Have you ever had a Mammogram or Breast Cancer Screening? Was it normal?

- **Do you live alone?**

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- **YOUR TOBACCO INTAKE**

| <b>TYPE SMOKED</b> | <b>DETAILS/QUANTITY</b> |
|--------------------|-------------------------|
| CIGARS             |                         |
| CIGARETTES         |                         |
| PIPE               |                         |
| OTHER TABACCO      |                         |

- **ALCOHOL INTAKE**

**1 UNIT = half pint beer/cider; 1 glass of sherry/wine; 1 single measure of spirits.**

| <b>TYPE</b>    | <b>QUANTITY PER WEEK</b> |
|----------------|--------------------------|
| <b>BEER</b>    |                          |
| <b>CIDER</b>   |                          |
| <b>SPIRITS</b> |                          |
| <b>WINE</b>    |                          |
| <b>OTHER</b>   |                          |

- **Do you, or have you ever, misused drugs/solvents?**
  
- **Do you have any allergies to any medication or foods?**
  
- **What form of contraception do you use, if sexually active?**
  
  
- **How much exercise do you do?**

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- **Is there anything you would like your GP to know about your personal life, childhood, education, your family, home life or accommodation?**

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**FAMILY HISTORY**

Please answer the following about your blood relatives, including your grandparents, to the best of your ability.

Is there a history of:

| <b>DISEASE/ILLNESS</b>           | <b>WHICH RELATION &amp; DETAILS</b> |
|----------------------------------|-------------------------------------|
| <b>HEART ATTACK</b>              |                                     |
| <b>HEART DISEASE</b>             |                                     |
| <b>HIGH BLOOD PRESSURE</b>       |                                     |
| <b>HIGH CHOLESTEROL</b>          |                                     |
| <b>STROKE</b>                    |                                     |
| <b>EPILEPSY OR FITS</b>          |                                     |
| <b>ASTHMA</b>                    |                                     |
| <b>ECZEMA</b>                    |                                     |
| <b>MENTAL ILLNESS/DEPRESSION</b> |                                     |
| <b>DIABETES</b>                  |                                     |
| <b>CANCER</b>                    |                                     |

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