# ST LUKES SURGERY - Patient Health Questionnaire

**DR CROSS. DR BARNARDO, DR MORRISON, DR XAVIER, DR CHARLWOOD & DR VICKERS**
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**PLEASE COMPLETE CLEARLY IN BLOCK LETTERS**

All new patients are requested to complete health questionnaire. It helps us to understand you better, prior to your full medical records arriving from your previous Doctor. All information provided on this form is kept strictly confidential.

## 1. Patient Details

| | | | |
|---|---|---|---|
| **Surname** (Family Name) | | **All Other Names** | |
| **Title** | **Gender** | **Marital Status** | |
| **Any Previous Surname (Family Name)** | | **Date Of Birth** | |
| **Town and Country Of Birth** | | | |
| **Main Language** | | **Do You Require An Interpreter?** | **Yes** / Please Circle / No |
| **Address** | **Name or Number:** / **Road:** | | |
| | **Town:** / **Postcode:** | | |
| **Home Tel. No.** | | **Mobile Tel. No.** | |
| **Email Address** | | | |
| **Emergency Contact** (Name And Relationship) | | | |
| **Contact Tel. No.** | | | |
| **Are You Or Do You Have A Carer?** | **Yes** / Please Circle / **No** | **NHS No.** | |

## IF YOU ARE UNDER THE AGE OF 12, PLEASE GO TO SECTION 5.

## 2. If Returning From Armed Forces

| | |
|---|---|
| **Address Before Enlisting** | |

**Please attach your signed Medical Form FP53 to realease your medical records.**

## 3. Current Health

| | | | | |
|---|---|---|---|---|
| **Height** | | | | |
| **Weight** | | | | |
| **Have You Ever Smoked?** | **Yes** | Please circle | **No** | |
| **Do You Currently Smoke?** | **Yes** | Please circle | **No** | |
| **How Many Per Day?** | | | | |
| **Do You Drink Alcohol?** | **Yes** | Please circle | **No** | |
| **How Many Units Per Week?** | | | | |

Please Answer In 'Units', 1 Unit = Half A Pint Of Beer/1 Glass Of Wine/A single Measure Of Spirits.

## 4. Adult Females Only

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Have You Ever Had A Cervical Smear?** | **Yes** | Please Circle | **No** | **Was It Done In The UK?** | **Yes** | Please Circle | **No** |
| **Was The Result Normal?** | **Yes** | Please Circle | **No** | | | | |
| **When Was It Done?** | | | | **Was It Done At A Clinic Or By Your Surgery/Practice** | **Clinic** | Please Circle | **SURGERY** |
| **Have you Ever Had A Breast Screening?** | **Yes** | Please Circle | **No** | **Was It Done In The UK?** | **Yes** | Please Circle | **No** |
| **Was The Result Normal?** | **Yes** | Please Circle | **No** | | | | |
| **When Was It Done?** | | | | | | | |

## 5. Children Only - Please List All Vaccinations

**PLEASE BRING THE RED BOOK TO RECEPTION.**

| Vaccination | Date | Location - What GP Surgery or Clinic? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 6. Medical History

**Do You Have Any Medical Conditions That We Should Be Aware Of? E.g. Diabetes, Asthma, Epilepsy, etc.**

**Any Current Medication/Treatment?** (Including Contraception Pill)

| | |
|---|---|
| | |
| | |
| | |
| | |

**Any Allergies To Drugs Or Other Materials?**

## 7. Ethnic Category

| | | | | | |
|---|---|---|---|---|---|
| **White -** | **British** | ☐ | **Mixed -** | **White Black Caribbean** | ☐ |
| | **Irish** | ☐ | | **White & Black African** | ☐ |
| | **Other** | ☐ | | **White & Asian** | ☐ |
| | | | | **Other** | ☐ |
| **Asian/Asian British -** | **Indian** | ☐ | **Black/Black British -** | **Black Caribbean** | ☐ |
| | **Pakistani** | ☐ | | **Black African** | ☐ |
| | **Bangladeshi** | ☐ | | **Other** | ☐ |
| | **Other** | ☐ | | | |
| **Other Ethnic -** | **Chinese** | ☐ | | **Prefer Not To Say** | ☐ |
| | **Other** | ☐ | | | |

**Thank You For Your Co-operation**

| | |
|---|---|
| **Signature** | |
| **Date** | |

**Do You Have Any Special Comnmunication Needs?**

**Yes** Please Circle **No**

**Are Any Special Communication Needs Requested?**

**Yes** Please Circle **No**

**Please Note Requirements:**

**Once Completed - Please Take This Form Along With Proof Of Identification (Passport/UK Driving License) and Proof Of Address.**

| For Official use ONLY | |
|---|---|
| Passport | ☐ |
| Visa | ☐ |
| Passport | ☐ |
| Uk Photo Driving License | ☐ |
| Utility Bill | ☐ |
| Tenancy agreement | ☐ |
| Bank Statement | ☐ |
| Checked by: | Date: |
| | |

## 8. Consent - General Data Protection Regulations

**Please tick this box if you DO NOT wish to receive text messages from the practice regarding your appointments and healthcare** ☐

**Please tick this box if you DO NOT wish to receive email messages from the practice regarding your healthcare** ☐

**We will contact you by telephone and email regarding appointments. Do you consent to this?**

**Yes** Please Circle **No**

**Signature**

**You have the right to change your mind at any point. Please contact reception if at any point you want to opt out.**