**Highland Medical Practice**

**‘At the Heart of Patient-Centred Care’**

**Bromley Site Orpington Site**

10 Highland Road 59 Sevenoaks Road

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Tel: 020 8460 2368 Tel: 01689 822017

**NEW PATIENT HEALTH QUESTIONNAIRE - CONFIDENTIAL**

Welcome to Highland Medical Practice. Please help us by completing this questionnaire, as it may take some time for your medical records to reach us from your previous GP. The information you give will be used to provide you with good medical care. All adults over the age of 16 years must personally submit their registration forms. Registration allows you to use both of our Surgery sites.

Our website address is [www.highlandmedicalpractice.co.uk](about:blank)

|  |  |
| --- | --- |
| **Full Name: ………………………………………….....................**  **Address:…………………………………………………………...**  **…………………………………………………………………...…**  **Home Tel. No:……..………………………………….…………..**  **Work/ Mobile Tel. No:……………………………………...…….**  **Email Address: ………………………………………………...…**  **Occupation: ………………………………………………………**  *(if under 16 years of age, please leave blank)*  **Next of Kin: ……………………… Relationship:………………**  **Next of Kin Tel. No:……………………...**……………………..... | **Date of Birth: …………………………..**  **Place of Birth:…………………………**  **Ethnicity:……………………………..**  **First Language:……………………….**  **Marital Status:………………………...**  **NHS No: ……………………………….**  **Permission to discuss medical details with Next of Kin** Yes / No |
| **CHILD REGISTRATION ONLY**  **Birth Certificate must be provided for new born babies & Red Book/ record of all immunisations received in the past must be brought to the appointment with doctor/ nurse.**  School attended (*if applicable*)…………………………………………………………………………….............  **Parent(s)/Guardian(s) Details**  Name(s): ……………………………………………………………………………………………………...........  Relationship(s):….………………………………………………………………………………………................  Address:…………………………………………………………………………………………………………….  ………………………………………………........................................................................................................... | |

**IMMUNISATIONS** – please list any vaccinations in the past & the dates you had them:

……………………………………………………………………………………………………………………...

Are all immunisations up to date, if NOT which ones are due?...............................................................................

**CURRENT AND PAST MEDICAL HISTORY**

Please give details of any illnesses, disabilities or operations (inc. dates if possible):

…………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Have you ever had any of the following? *(please indicate by circling the relevant illness)* | | | | | | | | | |
| High Blood  Pressure | Angina | Heart  Attack | Stroke | COPD | Diabetes | Glaucoma | Asthma | Cancer | Epilepsy |

**TREATMENT**

Please detail treatment/medication currently being received or attach a medication list, including repeat prescriptions:

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………………………………………………………………………………………………………………..

**PHARMACY NOMINATION** (for repeat medication) …………………………………………………..

**FAMILY HISTORY**

Has any member of your family suffered from any of the following?

Please indicate by ticking the relevant boxes and state which family member:

|  |  |  |
| --- | --- | --- |
| **Medical History** | At what age? | Which Family Member? |
| High Blood Pressure |  |  |
| Heart Disease |  |  |
| Stroke |  |  |
| Diabetes |  |  |
| Asthma |  |  |
| Other illnesses |  |  |

**ALLERGIES**

Are you allergic to any drugs? Please state which drugs:

…………………………………………………………………………………………………………………

Any other allergies? Please give details:

…………………………………………………………………………………………………………………

**FEMALE REGISTRATIONS**

When was your last Cervical Smear Taken……………………………………………………

**LIFESTYLE FACTORS – SMOKING**

|  |  |  |
| --- | --- | --- |
| Do you smoke? | Yes / No | If YES, how many cigarettes a day? ……………………………….  If YES, would you like us to help you quit? Yes / No |
| Did you ever smoke? | Yes / No | If YES, how many and when did you stop ……………………… |

**LIFESTYLE FACTORS – ALCOHOL**

|  |  |  |
| --- | --- | --- |
| How much alcohol, on average, do you drink in units each week? …………………………………………… | | |
| What type of alcoholic drink do you prefer? | Beers/Spirits/Wine | Other ……………………………….. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 unit is typically: | | |  |  | |  |  | | | | | |
| Half-pint of regular beer, lager or cider, 1 small glass of low ABV wine (9%),  1 single measure of spirits (25ml) | | | [ANd9GcSYFy5zNbDvyPZpn8N3lcmwZZgbP4lYlZxQ18ZfuQCBUS3U9kgZHY-kiZE](about:blank) | [ANd9GcRDh6cSdlgMu-8WUbNMVXdxuTgXCREGqoHBV2j1O67K-A5ly77MdLmzEQ](about:blank) | | [Half filled liquere carafe and tumbler isolated on white](about:blank) | [ANd9GcStfuwK3uS6x99qCrqW1ieb7huGTs_Hw-wO-62b5AoBJLSq1mFWIllTh6oy](about:blank) | | | [Entertain Cocktail Glasses 10.6oz / 300ml](about:blank) | | |
| The following drinks have more than I unit: | | 1.5 units  Bottle of lager  [ANd9GcSevIScRqjgC6TF-DUeqrBh7AVvj2YppP7M2u8TFxIDTYM6KXZ2XzWO948b](about:blank) | 2 units  Pint of lager  Click here to view | 3 units  Pint of strong beer ale  Click here to view | | 2 units  [ANd9GcQLPD9XXbeycLkKpYp0bUDK_1MhyVV2w2k-jNP4zEyQZuGla1ASUMNioTg](about:blank) | 4 units  ‘Super’ lager  [ANd9GcTYeackcHy__lhY9ya4CIwgNyj3aYWtIKtYy1OggE8EhjLCtl6OH0oBDOE](about:blank) | | 2 units  175ml of 12% wine  [ANd9GcQsiMJqdC20cuKdhyKu01xFgLGgbCcZntbCxeCvx1tlTtxJjtI6K1jzz8Up](about:blank) | | | 9 units  Bottle of wine  [ANd9GcSaaY98A8CByHSrwoHt0HsSZFFWhTqnqysJtk5IZmKK_rut6yVHnBLBL70h](about:blank) |
| **How often do you have a drink containing alcohol?** | Never | | Monthly  or less | | 2-4 times per month | | | 2-3 times per week | | | 4+ times per week | | |
| **How many units of alcohol do you drink on a typical day you are drinking?** | 1-2 | | 3-4 | | 5-6 | | | 7-9 | | | 10+ | | |
| **How often have you had 6 or more units if male, on a single occasion in the last year?** | Never | | Less than monthly | | Monthly | | | Weekly | | | Daily or almost daily | | |
| ***For Surgery use only*** |  | |  | |  | | |  | | | ***Score*** | | |

**Free chlamydia screening test (16-24years only)**

We are offering free STI screening to patients between 16-24 years due to rising rates of sexual transmitted infections. Often patients have no symptoms but the implications of being untreated can have serious long term consequences including infertility.

Yes, I would like to have a chlamydia screening test **⁭**

**HIV testing**

All adult patients in London are now being offered a free HIV test when they register with a new GP. The Department of Health recommends this as 100,000 people in the UK are now living with HIV, half of them live in London and 1 in 5 do not know they have it.

Yes, I would like to arrange a free HIV test **⁭**

**CARERS**

Do you have a carer? (if yes, please give details) ………………………………………………………………

If yes, permission to discuss medical details with Carer Yes / No ⁭

Are you a carer? (if yes, please give details) ……………………………………………………………………

…………………………………………………………………………………………………………………...

**SUMMARY CARE RECORDS**

This practice is Summary Care Record live, which means that your prescriptions, allergies and adverse reactions are saved on a central database for use by A & E and other care providers if you require treatment when the surgery is closed.

ARE YOU HAPPY FOR THE SHARING OF MEDICAL RECORDS TO APPROPRIATE HEALTH SERVICE PROVIDERS YES/NO………………………………………………….

**PATIENT ACCESS**

Patient Access is a service allowing our patients to access our practice on-line. This service allows you to order repeat prescriptions, view your summary car record and book/ cancel appointments. You can register for this service directly from our website: [www.highlandmedicalpractice.co.uk](about:blank)

**HOW DID YOU HEAR ABOUT US?...................................................................................................................**

**CONTACTING YOU**

|  |  |
| --- | --- |
| I understand that I may be contacted from time to time, via phone, post, email and/or text message, with practice news, advice about my health, notification of receipt of results (the actual results will not be sent via email or text) and/or appointment reminders**.** | Yes / No ⁭ |

Patient’s signature ……………………………………………… Date ……………………………