Beech House Surgery

New Patient Health Questionnaire

SURNAME: Mr/Mrs/Ms/Miss	FORENAME(S)
DATE OF BIRTH: SEX: (M/F):	

Ethnicity: Please tick the one that applies to you

White British		White & Black Caribbean		Asian Indian		Black Caribbean	
White Irish		White & Black African		Asian Pakistani		Black African	
White Other		Other Mixed Background		Asian Bangladeshi		Black Other	
Chinese		Other Asian		Other Ethnic Group		Not Given	

Language: Please indicate what you consider to be your first language?

English: Yes/No:
Other Language —Please Indicate:
If English is not your first language, do you speak English? Yes/No

What is your current smoking status?

Never Smoked			
Passive Smoker			
Ex-Smoker		When did you give up?	
Current Cigarette Smoker		Number per Day?	
Current Pipe Smoker		Grams per Day?	
Current Cigar Smoker		Number per Day?	
Are you interested in stopping? Yes or No? - if 'Yes' we will arrange for you to see our smoking cessation advisers			

Alcohol Consumption

Wine	Number of glasses per week	
Beer	Number of pints per week	
Spirits	Number of singles per week	
How often do you drink Alcohol?	A. Never B. Monthly or less C. 2-4 times per month D. 2-3 times per week E. 4 or more times per week	O O O O O
How many standard drinks containing alcohol do you have on a typical day?	A. 1 or 2 B. 3 or 4 C. 5 or 6 D. 7 to 9 E. 10 or more	O O O O O
How often do you have six or more drinks on one occasion?	A. Never B. Less than Monthly C. Monthly D. Weekly E. Daily or almost Daily	O O O O O

HEIGHT:(cms):
WEIGHT:(kgs)

Do you take regular exercise? *- please tick one that applies to you*

Exercise is physically impossible		I enjoy moderate exercise	
I avoid even trivial exercise		I enjoy heavy exercise	
I enjoy light exercise		I am a competitive athlete	

Please turn over

Clinical Review:	
Are you taking any regular (daily/weekly etc.) medication? *(Attach a copy of your current prescription if you can).*	Details:

Health—please place a 'tick' in the box to indicate if you have, or have had, the following diseases and whether there is a history of the disease in your family.

Disease	Personal History	Family History	Relative Involved	Age of Relative
Asthma				
Chronic Obstructive Pulmonary Disease (COPD)				
Diabetes				
Ischaemic Heart Disease				
High Blood Pressure - Hypertension				
Stroke				
Glaucoma				

Allergies Do you suffer from any allergies, Yes/No	Please state:	
Other—please note if you have any other ongoing medical issues		
Are you Adopted (Y or N) - delete as appropriate	Yes/No	

Signed:	**Date:**