Collingwood Road Surgery
40 Collingwood Road
Witham, Essex CM8 2DZ

NEW PATIENT HEALTH QUESTIONNAIRE

Title: **First name:** **Middle name:**

Surname: **Previous Surname:**

Date of Birth:

Home Address:

Post Code:

Key Code:

Place of Birth:

Telephone Number Home: Mobile:

Email address:

Consent to be contacted via SMS – Y / N **Consent to be contacted via email** – Y / N

NHS number:

Marital Status:

Gender:

Occupation:

Pharmacy for electronic prescriptions to be sent to:

If from abroad, **date of entering the UK**:

Ethnicity:
First language:
If English is not your first language, **do you speak English**? – Y / N

Next of kin – Name: Relationship:
Telephone number:

Do you have a carer – Y / N Carer name: Telephone number:
Are you a carer – Y / N Who do you care for?

GENERAL HISTORY

Past medical history (provide details)?

Are you currently taking any medication (provide details)? You may require an appointment before a prescription can be issued.

Do you have any allergies (provide details)?

FAMILY HISTORY

Do you have any family history of illness, ie heart disease, cancer, diabetes etc (provide details)?

Blood pressure:

Height (cm) : **Weight** (kg) :

Are you a smoker? – Y / N If yes, how many cigarettes do you smoke per day?

Are you an ex-smoker? – Y / N If yes, when did you stop smoking?

What is your average weekly alcohol consumption?

Record Sharing

Consent to hold, process and share manual and electronic records and data in accordance with the Data Protection Act 2018, the Caldicott Report, and other relevant Information Governance legislation.

When you are registered at the practice, your details will be shared, as appropriate:

- With members of the practice health care team
- With other healthcare professionals involved in my care
- For the purposes of practice administration

Do you consent to the sharing of data recorded here with any other organisations that may care for you? – Y / N

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make the data shareable? – Y / N

ALL PATIENTS:

I confirm that the information given is true to the best of my knowledge.

Signed: …… Date: ……..
