

**CHEVIOT ROAD SURGERY
NEW PATIENT HEALTH QUESTIONNAIRE**

**AGES
16+ YEARS**

NAME OF PATIENT:

HOME ADDRESS:

DOB:

CONTACT NUMBER/S:

Do you wish to be contacted by text message? YES NO

EMAIL ADDRESS:

ETHNIC GROUP:

LANGUAGE: **INTERPRETER REQUIRED:**

DO YOU HAVE A SOCIAL WORKER? YES NO

Have you ever had any of the following?

	NO	YES
Allergies		
Angina, heart attack, or any other heart trouble		
Strokes or mini-strokes (TIAs)		
High blood pressure		
Diabetes		
Asthma Chronic Bronchitis or Emphysema		
Epilepsy, fits or seizures		
Thyroid problems		
Cancer of any type		
Learning Disabilities		
Significant Mental Health problems or severe depression		
Any other serious illnesses that you feel may be relevant? Please list below		

Which of the following best describes you?

I have never smoked

I have smoked in the past but do not smoke now

I am a current smoker. Please list how many cigarettes/cigars etc you smoke per day

SMOKING TOBACCO IS HARMFUL. If you are a smoker and would like to quit, please speak to your Doctor or Practice Nurse.

<p>NEXT OF KIN OR CONTACT IN AN EMERGENCY NAME ADDRESS CONTACT NUMBER RELATIONSHIP</p>
