NEW PATIENT HEALTH CHECK FORM

Welcome to the Amwell Group Practice

The purpose of this questionnaire is to let us know about your health, and factors that may affect your health. Any information given is entirely confidential to the practice. If you have any queries about this questionnaire, please mention them when you see the doctor or nurse. **Please complete both sides and fill in as much detail as possible.**

Family Name/Surname:	Address:
First Name:	
Date of Birth:	
Ethnic Origin:	Post Code:
First Language:	Home Telephone:
Mobile Telephone:	Work Telephone:
Male ☐ Female ☐ Gender Neutral ☐ Other, please specify……..	
Next of Kin:	Telephone No……
Are you a Carer? YES / NO	**If yes who do you care for……**
Do you have a Carer? YES / NO	**If yes please give their name…….**

About Your Lifestyle			
Weight (kg or stone)	……	**Height (cm or feet & inches)**	……..
Do you smoke?	**Delete as appropriate** YES / NO	If yes, how cigarettes per day?	**Number/Date** ……..
Have you smoked in the past?	YES / NO	If yes, how cigarettes per day? When did you stop?	…….. ……(Year)
Do you drink alcohol?	YES / NO	If yes, how many drinks per week? (1 drink equals ½ pint of beer or 1 glass of wine or a single measure of spirits).	……..
Men: How often do you have **EIGHT** or more alcoholic drinks on one occasion? *Please tick appropriate box:-* Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐			
Women: How often do you have **SIX** or more alcoholic drinks on one occasion? *Please tick appropriate box:-* Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐			
Do you take regular exercise?	YES / NO	If yes, what sort of exercise and how often?	
How would you describe your diet?	Balanced / Unhealthy	Any special diet? *(e.g. diabetic, vegetarian):*	
BP Reading **To be taken on the POD at the reception desk**	..... MM/HG		

Are You: Single / Married / Divorced / Separated / Widowed / Cohabiting **(please circle)**

Are you: Employed / Unemployed / Studying / Retired / Full time parent **(please circle)**

Please state your usual occupation. ……

Have you any problems that it might help your doctor to know regarding your personal life, your childhood or your accommodation?	If yes, please comment here.

FAMILY HISTORY				
	First Name	Year of Birth	Any serious illness	If applicable, Age and Cause of Death
Mother				
Father				
Brother 1				
Brother 2				
Sister 1				
Sister 2				
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				

Have you had any major illnesses, hospital admissions or operations? **Please state where and when.**
(e.g. appendicectomy, tonsillectomy, heart attack, hospital tests) ***Where***
Date

Do you suffer from any ongoing illness? *(e.g. high blood-pressure, diabetes, asthma, depression)*

Do you take any medication? What medicine and how often do you take it?

Are you allergic to any medicines? If yes, what happened?

Vaccinations	**Delete as appropriate**	**Date of last vaccination (if known)**
Do you have a yearly Flu vaccination?	YES / NO	
Have you had any vaccinations before travelling abroad?	YES / NO	

<u>For Women Only:</u>
Please give details of any pregnancies, including any problems during pregnancy, any miscarriages or terminations.

When and where was your last smear taken? **What was the result?**	(Date)…… (Result)……	
Have you ever had an abnormal smear?	YES / NO	If yes, ……..(Date)
If you are between 50-65 years, have you had a breast screening mammogram?	YES / NO	If yes, ……..(Date)
What, if any, form of contraception do you use?		

Thank you for your help. Please give this completed questionnaire to a receptionist or to the doctor or nurse when you see them.