The Manor Practice

New Patient Health Questionnaire

12 Years of Age & Over

Southwick Street, Southwick, West Sussex, BN42 4TA 01273 596077 / 592723

Please ensure all questions on this form are completed. Incompletion of this form may result in your registration being delayed.

Name:_____ **Sex: M/F** **DOB:**_____

Address:_____

Tel No:_____ **Work No:**_____

Mobile No:_____ **I consent to receiving text messages from the surgery Yes / No**

Email Address :_____

Next of Kin (Name & Address) :_____

Relationship to patient:_____ **Tel No:**_____

Please be aware. The Manor Practice use a software called MJOG which is an automated appointment reminder, sending appointment reminder text messages to your mobile that requires no human interaction and therefore ensures that your medical records are still kept completely confidential. If you provide us with your mobile number, it will automatically be used for this service. If you do not wish to receive text message reminders. Please inform reception.

Ethnicity ***(Ethnicity: This is your cultural background, please do not put your Nationality, i.e. your Place of birth.)***

We are ask for your ethnicity because all ethnicities have tendencies towards certain illnesses and conditions – from CHD to diabetes, sickle cell anaemia, mental health disorders, cancer and more. By recording ethnicity the NHS hopes to understand who is using our services, and if all people are getting the same benefits from NHS care – such as screening and health promotion, to help identify the needs of different ethnic communities and to ensure that appropriate services are provide and to comply with the Race Relations (Amendment) Act 2000, which makes it compulsory to promote race equality in the NHS. The Act demands that people from different ethnic groups should enjoy equal access to health services

White	Asian/Asian British	Black/Black British	Mixed	Other
British ☐	Indian ☐	Caribbean ☐	White & Black Caribbean ☐	Chinese ☐
Irish ☐	Pakistani ☐	African ☐	White & Black African ☐	Other ☐
Scottish ☐	Bangladeshi ☐	Other ☐	White & Asian ☐	
Other ☐	Other ☐		Other ☐	

First Spoken Language

Albanian ☐	English ☐	Italian ☐	Punjabi ☐	Slovak ☐
Arabic ☐	Ethiopian ☐	Japanese ☐	Romanian ☐	Thai ☐
Bengali ☐	Finnish ☐	Korean ☐	Russian ☐	Turkish ☐
Bulgarian ☐	Flemish ☐	Kurdish ☐	Serbian ☐	Ukrainian ☐
Cantonese ☐	French ☐	Lithuanian ☐	Somali ☐	Urdu ☐
Croatian ☐	German ☐	Norwegian ☐	Spanish ☐	Vietnamese ☐
Czech ☐	Greek ☐	Polish ☐	Swahili ☐	Welsh ☐
Dutch ☐	Hebrew ☐	Portuguese ☐	Swedish ☐	

Carer Registration

If you care for, or help, someone with an illness or disability, whether this is a partner, friend, other relation or even a neighbour – then you are a CARER.
Please see our Notice board in the waiting room for more information.

Are you a Carer? Yes ☐ No ☐ Do you have a Carer? Yes ☐ No ☐

Name & Address of person you care for or your Carer:_____

_____

Women Only

Are you pregnant? Yes☐ No☐ If yes, your expected date of confinement:_____
(Please obtain your Maternity Pack from Reception)

Have you a Coil or Norplant? Yes☐ No☐ If yes, what year was it fitted:_____

Date of your last Coil / Norplant check:_____

General Health Information -

Height:	Weight:	Waist Circumference:

Please measure your height and weight in the health screening area

Blood Pressure
Please record your blood pressure on our Blood Pressure Machine

Blood Pressure Reading: _____ / _____

1. *Smoking* - Have you ever smoked? Yes ☐ Please read questions 2 & 3. No ☐ Please go to next section

2. If you do smoke, how many do you smoke a day?___ 3. If you are an ex-smoker, when did you give up? ___

Smoking Advice
The single most useful thing you can do to help your health is to STOP smoking and never to start if you are a non-smoker. **If you are a smoker and wish to give up, please speak to reception about seeing our Smoking Cessation Advisor.**

Alcohol - Do You Drink Alcohol? Yes ☐ No ☐ If yes, please state how many units you drink per week,

(1 glass of wine, ½ pint of beer, 1 measure of spirit} = 1 UNIT)_____Units per week.

Do you have a Family History of :	
Heart Disease Under 60yrs	Yes ☐ No ☐ Relation to you_____
Heart Disease Over 60yrs	Yes ☐ No ☐ Relation to you_____
CVA / Stroke	Yes ☐ No ☐ Relation to you_____
Diabetes	Yes ☐ No ☐ Relation to you_____
Asthma	Yes ☐ No ☐ Relation to you_____

Other information

- Do you have a long term medical condition (ie diabetes) ?

_____