Bolingbroke Medical Centre

Bolingbroke Medical Centre
Wakehurst Road
Battersea
London
Tel: 020 7801 1460 | Fax: 020 7801 0748

NEW PATIENT HEALTH QUESTIONNAIRE

Name	
Date of Birth	
Address	
Occupation	

General Health

1. Do you have or have you ever had any of the following:-

Diabetes	YES	NO	Heart Problems	YES	NO
Asthma	YES	NO	Stroke	YES	NO
COPD	YES	NO	Epilepsy	YES	NO
Thyroid Problems	YES	NO	High Blood Pressure	YES	NO

2. Have you had any serious illness or operations? If so, please list:

3. What medication are you currently taking? Please list including dosage:

4. Are you allergic to anything?

Your Lifestyle

Current Smoker		Number per day:	
Ex Smoker		Year stopped:	
Passive Smoker			

Never Smoked											

Alcohol Consumption										9k17.00	9k19.11
How often do you have a drink that contains alcohol?											
Never		Monthly or less		2-4 times per month		2-3 times per week		4 + times per week			
How many standard alcoholic drinks do you have on a typical day when you are drinking?											
1 – 2		3 - 4		5 - 6		7 - 8		10 +			
How often do you have 6 or more standard drinks on one occasion?											
Never		Less than monthly		Monthly		Weekly		Daily or almost daily			

Diet						
Vegetarian	YES	NO	Vegan	YES	NO
Low Fat	YES	NO	Weight reducing	YES	NO
Other (please specify)					

Exercise Grading			
Exercise on a regular basis		Exercise occasionally	
Do not exercise		Physically impossible to exercise	
If you do exercise, please state what activity or exercise is undertaken			

Your Family History			
Blood relatives only:- please state relationship to you			
Heart Problems	YES	NO	
Diabetes	YES	NO	
Asthma	YES	NO	
Stroke	YES	NO	
High Blood Pressure	YES	NO	
TB	YES	NO	
Other serious illness	YES	NO	

Other Questions			
Would you like to have a HIV test?	YES	NO	
If you are aged 15-24 would you like to be screened for Chlamydia?	YES	NO	

If you are aged 40-74 would you like a New Patient health Check?	YES	NO	
Do you consent for Summary Care Records sharing?	YES	NO	
If you use EPS, do you want to change your nominated pharmacy?	YES	NO	
Please provide your blood pressure reading (you can use our automatic blood pressure unit in the waiting room)			
What is your height and weight?	Height:		Weight:

Carer Information			
Are you a Carer?	YES	NO	
Name of person(s) cared for:			
Is this person at this practice	YES	NO	

Signed:	
Dated:	

Thank you for your time

PATIENT ETHNIC ORIGIN FORM

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your first language and ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Name…….. **Date of Birth……..**

First Language English ☐ Other ☐ If Other please specify _____

Ethnicity. Choose ONE section below and then tick ONE box to indicate your background.

White

British		9i0
Irish		9i1
Any other white background please write in below		9i2

Mixed

White and Black Caribbean		9i3
White and Black African		9i4

White and Asian		9i5
Any other mixed background please write below		9i6

Asian or Asian British

Indian		9i7
Pakistani		9i8
Bangladeshi		9i9
Any other Asian background please write below		9iA

Black or Black British

Caribbean		9iB
African		9iC
Any other black background please write below		9iD

Chinese or other ethnic group

Chinese		9iE
Any other please write in below		9iF

Declined		9SD

Shaded areas for office use only