NEW PATIENT HEALTH QUESTIONNAIRE

EASY READ VERSION

Please speak to our reception team if you would like help with this form. Please use black pen.

Your first name:

Your last name:

Your date of birth: / /

Day Month Year

Your address:

Your postcode:

Your home phone number:

Your mobile phone number:

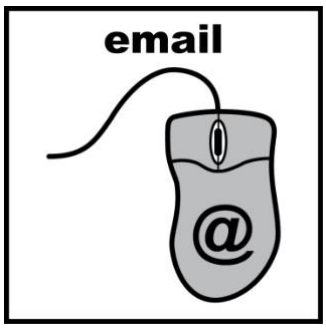
How can we contact you? Please tick any boxes that apply.

Phone: Yes ☐ No ☐

Email: Yes ☐ No ☐

Text: Yes ☐ No ☐

Letter: Yes ☐ No ☐



Do you have an email address: ☐

What is your ethnicity: ☐

Do you need an interpreter?

Yes ☐ No ☐

Do you have a carer or keyworker?

Yes ☐ No ☐

What is their name:

What is their phone number:

Do you have any allergies?

Yes ☐ No ☐

What are you allergic to:

Do you drink alcohol?

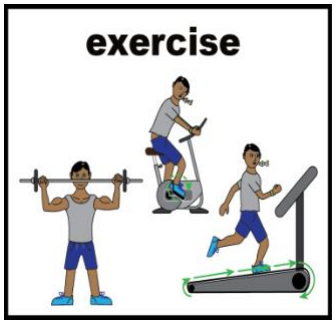
Yes ☐ No ☐

How many glasses each week

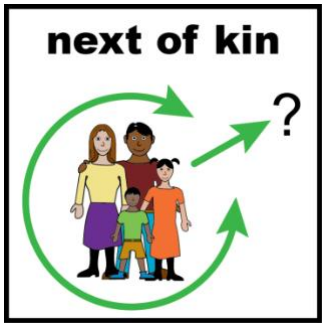
Do you smoke?

Yes ☐ No ☐

How many cigarettes do you smoke each day?



How many hours do you exercise each week:



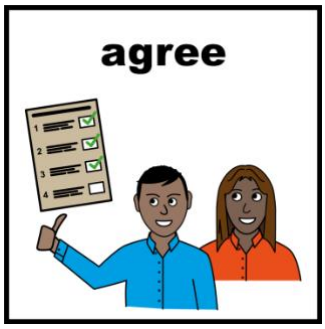
What is the name of your next of kin:

What is their telephone number:

What is their relationship to you:

What is their date of birth:

What is their address:

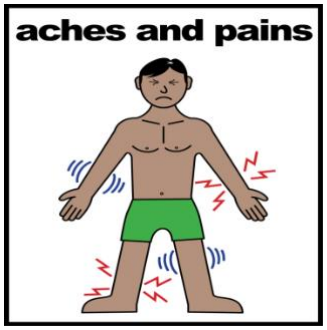


Do you agree to share your medical information with them?

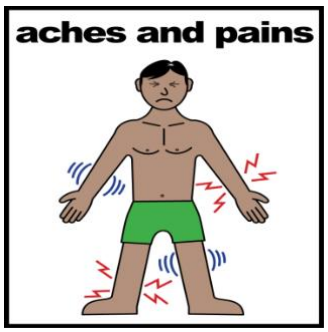
Yes ☐ No ☐

Do you have a health action plan:

Yes ☐ No ☐



Do you have any long term illnesses?



Does anyone in your family have a long term illness?

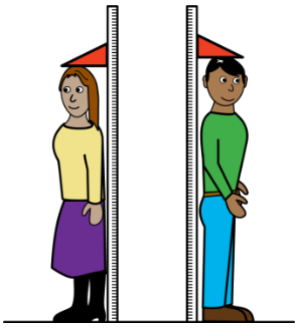
Yes ☐ No ☐

Please give us a bit more information if you ticked the yes box.

Who is ill?

What is the illness?

Please answer the following questions. We have equipment in the waiting room for you to use. Please ask the receptionist if you would like any help.

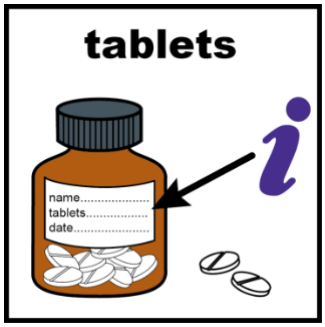


Please tell us how tall you are in centimetres.

Please tell us your weight in kg.

Please tell us your blood pressure reading.

DIA SYS PUL



Please tell us if you take any medication.

Would you like to collect your prescription from a pharmacy.

Yes ☐ No ☐

Please tell us the pharmacy name you would like to collect from.

Please inform us if you have any additional information and/or communication needs. This will help us better communicate with you.

We will record your needs on your medical notes.

We may share this information with other care providers.

Please let us know if your choice of communication changes.

Signature.

Date.