The Bell Surgery

New Patient Health Questionnaire

To help us provide good patient care to you as a new patient, please complete this Health Questionnaire. This information will help your new Doctor provide the right care to you until your medical records arrive from your previous Doctor. Please complete the form then save and email it to the thebellsurgery@nhs.net or print off and return a copy to our Reception team.

Full Name: Click here to enter text.	Date of Birth: Click here to enter text.
Address: Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Post Code: Click here to enter text.	Tel no. Home: Click here to enter text. Tel no. Work: Click here to enter text. Mobile No: Click here to enter text.
E mail address: Click here to enter text.	Next of kin. Name: Click here to enter text. Contact no : Click here to enter text.
Occupation: Click here to enter text.	Have you ever served in the armed forces? Choose an item.
Are you a carer? Choose an item.	Do you have a carer? Choose an item.
Ethnic Group Choose an item.	
Height: Click here to enter text.	Weight: Click here to enter text.
Do you smoke? Choose an item.	Have you ever smoked? Choose an item.
	Date stopped: Click here to enter text.
Do you drink alcohol? Choose an item.	If yes, how often do you have a drink containing alcohol? Choose an item.
How many units of alcohol do you drink on a typical day when you are drinking?	Choose an item.
How often have you had 6 or more units if female or 8 or more if male, on a single occasion in the last year?	Choose an item.
Do you exercise? Choose an item.	Please select from the options listed: Choose an item.

Do you currently suffer from, or have you ever had, any significant health problems or operations?

e.g. Angina, Asthma, Cancer, Depression, Diabetes, Epilepsy, Heart Attack, High BP, Stroke etc Choose an item.
If yes please give details below:

Date	Condition	Treatment

Are you taking any tablets or medicines at the moment? Choose an item.

Name of Medicine	Strength	Dose

Are you allergic to anything? Choose an item.
If yes please give details:

Have you had a course of vaccinations in the last ten years? Choose an item.
If yes please give details including dates:

For Women:
When and where was your last cervical smear taken? Click here to enter a date.
Have you had a hysterectomy? Choose an item.
Did you have the menopause before age 45? Choose an item.
Have you ever had a bone scan? Choose an item.
Have you had a breast screening test? Choose an item.
Are you taking oral contraceptives? Choose an item.
If you have children under 18, please give their dates of birth:Click here to enter text.

Patient's Signature: Click here to enter text.

Date:Click here to enter text.

- Please note that if you are currently on medication we request that you arrange an appointment to see your new GP.
- If you are aged between 40-74, have no pre-existing medical conditions and have not had a Health Check within the past 5 years you are entitled to a free NHS Health Check. Please speak to our Receptionists for details.