



# UEA MEDICAL CENTRE - NEW PATIENT HEALTH STATUS QUESTIONNAIRE

Office use only;	
EMIS No.	
Reg clerk	
Reg date	
Eligibility	
*Appt	

Please answer the following questions as accurately and completely as you can, as they will form a part of your medical record.

All information will remain confidential – This form has two sides

Last Name: \_\_\_\_\_ Forename: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

UEA School: \_\_\_\_\_ Year of study: (tick)  UG 1<sup>st</sup>  UG 2<sup>nd</sup>  UG 3<sup>rd</sup>  UG other  PG 1<sup>st</sup>  PG other  Non-student Course end date (year): \_\_\_\_\_

\*UK Mobile number: \_\_\_\_\_ Email address: \_\_\_\_\_  
 \*Tick if you wish to **opt out** of mobile text message reminders *NB/ We may use your email address for medical correspondence*

Nationality: \_\_\_\_\_ Main spoken language: \_\_\_\_\_

**Ethnicity (please tick one box)**

- |   |  |   |   |   |
|---|--|---|---|---|
| <b>White</b>                                    | <b>Mixed</b>                                     | <b>Asian or Asian British</b>                   | <b>Black or Black British</b>                   | <b>Other Ethnic Groups</b>                  |
| <input type="checkbox"/> British                | <input type="checkbox"/> White & Black Caribbean | <input type="checkbox"/> Indian                 | <input type="checkbox"/> Caribbean              | <input type="checkbox"/> Chinese            |
| <input type="checkbox"/> Irish                  | <input type="checkbox"/> White & Black African   | <input type="checkbox"/> Pakistani              | <input type="checkbox"/> African                | <input type="checkbox"/> Other ethnic group |
| <input type="checkbox"/> Other White background | <input type="checkbox"/> White & Asian           | <input type="checkbox"/> Bangladeshi            | <input type="checkbox"/> Other Black background | <input type="checkbox"/> Prefer not to say  |
|   | <input type="checkbox"/> Other mixed background  | <input type="checkbox"/> Other Asian background |   |   |

**! IMMUNISATIONS – ESSENTIAL INFORMATION REQUIRED \*YOU MUST COMPLETE THIS SECTION\***

You are strongly advised by the UEA, INTO & UEA Medical Centre to ensure you are fully immunised to UK Department of Health standards. **There is an increased risk of Meningitis, Measles, Mumps and Rubella due to the large numbers of students in the close confines of a university campus, therefore it is important that you are vaccinated to protect both yourself and others.**

**Please indicate if you have/have not had the following;**

- Meningitis ACWY vaccine**  Yes, date (MMYY) ..... **OR**  Yes, had but unsure of date **OR**  \*No, not had
- 1<sup>st</sup> MMR (measles, mumps, rubella) vaccine**  Yes, date (MMYY) ..... **OR**  Yes, had but unsure of date **OR**  \*No, not had
- 2<sup>nd</sup> MMR (measles, mumps, rubella) vaccine**  Yes, date (MMYY) ..... **OR**  Yes, had but unsure of date **OR**  \*No, not had

**Q1** Have you lived in a country other than the UK for 6+ months in the last year?  No  Yes; if yes, where?  
 (please write below)

**Q2** Have you been diagnosed with any of the following conditions?  No - none  Yes - Please tick those that apply;

- Diabetes
- Eating disorder
- Epilepsy
- Hypothyroidism (low/underactive)
- Mental illness requiring treatment

- \*Hypertension (Raised Blood Pressure)
- \*Coronary Heart Disease (CHD)
- \*Congenital Heart Disease
- \*Cancer (active within the last 2 years)
- Asthma

If you have ticked Asthma, please tick the following - if they apply;

- \*I have used an inhaler within the last 18 months
- \*I use an inhaler 3+ times per week

**Q3** Do you take any prescribed medication at present?  No  Yes; if yes, what (Please include the pill and depo-injection)

.....  
 .....  
 .....

**Q4** Do you have any allergies?  No  Yes; if yes, what:

.....  
 .....

**Q5** What is your: Height? ..... (cm/ft inches)      Weight?.....(kilo/stone)

**Q6** Have you had/do you suffer from any \*serious illness? [ ] No [ ] Yes; if yes, what and when

1. ....(Date).....

2. ....(Date).....

**Q7** Have you had any significant injuries or operations? [ ] No [ ] Yes; if yes, what and when

1. ....(Date).....

2. ....(Date).....

**Q8** Have you any disability/communication needs? [ ] No [ ] Yes; if yes, what .....

**Q9** Do any of your parents/brothers/sisters suffer from any of the following medical problems? [ ] No [ ] Yes; if yes, what/who?

[ ] \*Heart disease at an early age      Who? .....

[ ] \*High cholesterol      Who? .....

[ ] High blood pressure      Who? .....

[ ] Cancer      Who? .....

[ ] Diabetes      Who? .....

**Q10 FEMALES ONLY - please answer this boxed section if applicable**

a) Have you ever been sexually active? [ ] No [ ] Yes      b) Do you require contraception? [ ] No [ ] Yes

c) When was your last cervical smear/PAP? (date/year).....

d) Have you ever had an abnormal smear/PAP? [ ] No [ ] Yes; if yes, what was the date/year? .....

e) Number of pregnancies .....

**Q11** Do you smoke? [ ] Never [ ] Used to (not now) [ ] Current smoker – how many per day? .....

**Q12** Do you drink alcohol? [ ] No [ ] Yes; if yes, please proceed to the questions below and circle your answer:

QUESTIONS	SCORING SYSTEM				
	0	1	2	3	4
How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Daily or almost daily

**\*\*\*PLEASE READ THIS SECTION CAREFULLY\*\*\***

**Confidentiality & data protection statement:** The practice treats the information you provide as confidential. Further information about how your data is used is available to view on our website. **The following systems use your data – please tick against the relevant statement(s) if you wish to OPT OUT of any. If you do not tick any, we will take this as your agreed consent to the data extractions.**

1. <b>Summary Care Record (SCR)</b> - A national NHS system where a summary of your GP medical record (such as significant diagnoses, allergies & medications) is available to be accessed by other healthcare providers across the country. Use of this system is audited.	[ ] Tick to opt out
2. <b>Care.Data (please note: The Government has put this initiative on hold for the moment)</b> - NHS England can instruct the Health and Social Care Information Centre (HSCIC) to extract patient identifiable, medical information stored in your GP record, to enable them to carry out national audits/identify trends and other analysis of this information. HSCIC can then pass this information onto other organisations/third parties for use as they see appropriate.	[ ] Tick to opt out

\*\*Any other relevant information – please add here

**COMPLETION OF THIS QUESTIONNAIRE DOES NOT REGISTER YOU WITH A DOCTOR**

We need to receive your signed GMS1 (GP registration) form in order for you to be registered

Office use only: [ ] HC not required [ ] \*HC offered [ ] HC refused [ ] \*TB screen only [ ] \*Imms required [ ] Practice leaflet given at reg [ ] Dr appt needed [ ] Smoking Cessation

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