EASY READ NEW PATIENT HEALTH QUESTIONNAIRE

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

Do you have a religion?

Yes ☐ No ☐

What is your religion?

☐

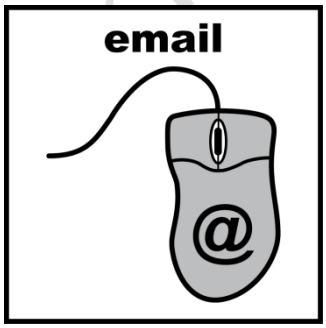
How can we contact you? Please tick any boxes that apply.

Phone: Yes ☐ No ☐

Email: Yes ☐ No ☐

Text: Yes ☐ No ☐

Letter: Yes ☐ No ☐



Please tell us your 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 first name:

What is their last name:

What is their phone number:

Do you care for someone that has a long-term illness?

Yes ☐ No ☐

Please tell us the name of the person you care for:

First Name

Last Name

Do you have any allergies?

Yes ☐ No ☐

What are you allergic to:

Do you drink alcohol?

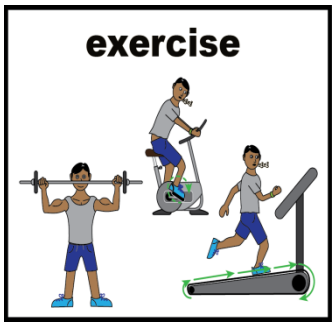
Yes ☐ No ☐

How many glasses each week

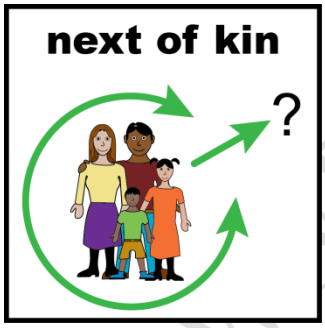
Do you smoke?

Yes ☐ No ☐

How many cigarettes do you smoke each day?



How many hours do you exercise each week:



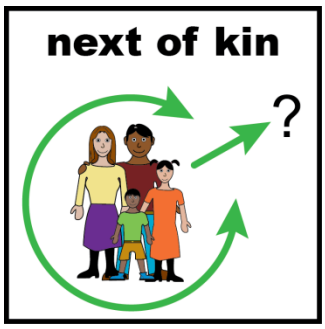
What is the first name of your next of kin:

What is the last 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?

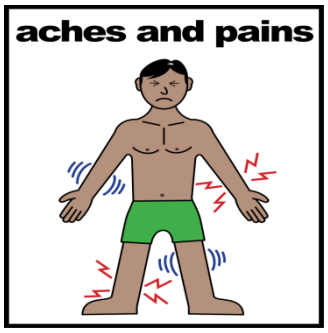
Yes ☐ No ☐

If you agree, we need you to send a letter telling us that this is ok. If you need help, please speak with the receptionist.

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?

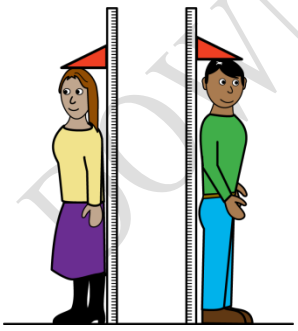
Yes ☐ No ☐

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

Who is ill?

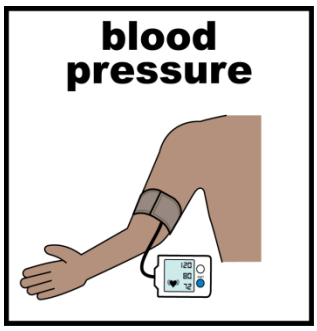
What is the illness?

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.

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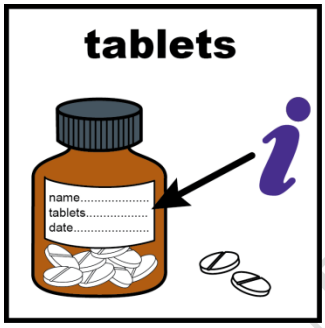
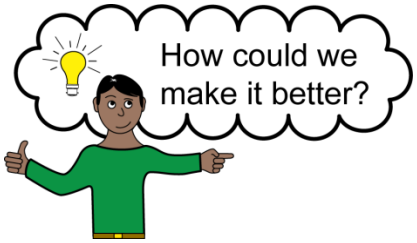


Please tell us if you take any medication.

We will send your prescription to a pharmacy

Please tell us the name of pharmacy you would like to collect your medication 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.

It is important that we know how to contact you.

Please sign your name in the box below.

Signature.

Date.