Ormeau Health Centre

NEW PATIENT HEALTH QUESTIONNAIRE-Please answer all questions in clear print.

Name………………………………………………………………**Today's Date**……………………………..

Address…………………………………………………………….**Post Code**………………………………..

Date of Birth………………………

Telephone No* ………………………………………(**PREFERABLY A MOBILE TELEPHONE NUMBER)**

Email Address ……………………………………

***In the future the Practice may start sending you text messages; if you DO NOT CONSENT to this please advise the Receptionist.**

Are you? (Please circle as appropriate) **Seeking Asylum (13ZN)** **Illegal Immigrant (13D4)**

Any Operations? ………………………………………………………………………Year……………………

………………………………………………………………………..Year……………………

………………………………………………………………………...Year……………………

History of Illness? ……………………………………………………………………..Year……………………

………………………………………………………………………Year…………………….

………………………………………………………………………...Year……………………

Do you have any Allergies? Yes /No Please specify …………………………………………………………

Do you take any Medication? Please list names, strengths and how many you take:

………

………

Family History: Heart Disease **YES/NO** Family Member…………………………
Cancer **YES/NO** Family Member…………………………

Smoking Status: Never Smoked Current Smoker inc Pipe Ex-Smoker
How many per day…………… Date you Quit……………………..

Alcohol: **YES/NO** Units per week…………Do you exercise? **YES/NO** Weight……………Height…………..

Have you had any Immunisations/Vaccinations?...

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For Women: Date of last Smear Test………………… Where was it done?...

Have you had any children? **YES/NO** How many?...........................Have you had a Breast Check?..........................

TB Screening Questionnaire

This **MUST** be completed if you are a new Immigrant

Name …………………………..   DOB ……………………………

Today's Date…………………….   Country Of Origin……………..

Date of Arrival………………….

Health Questionnaire	Yes	NO
Have you ever received a BCG vaccination?		
If YES do you have a BCG Scar?(If yes please state where)		
Have you had a recent chest X-Ray?		
Have you ever been in contact with any one who has active tuberculosis?		
Do you suffer with a persistent cough?		
Do you suffer from night sweats?		
Is your appetite poor?		
Have you lost weight recently?		

To ensure we have as much information about you as possible and to make it possible for us to treat you to the highest standard, please take time to complete these last few questions.

HIV

Have you ever been counseled or tested for HIV (Please Circle)   Yes / No

Do you need counseling or testing for HIV (Please Circle)   Yes / No

Hepatitis

Have you ever been counseled or tested for Hepatitus (Please Circle)   Yes / No

Do you need counseling or testing for Hepatitus (Please Circle)   Yes / No

Complex Needs

Do you have complex clinical needs that will require extra assessment?   Yes / No

Do you need an interpreter when you see the Dr?   Yes / No