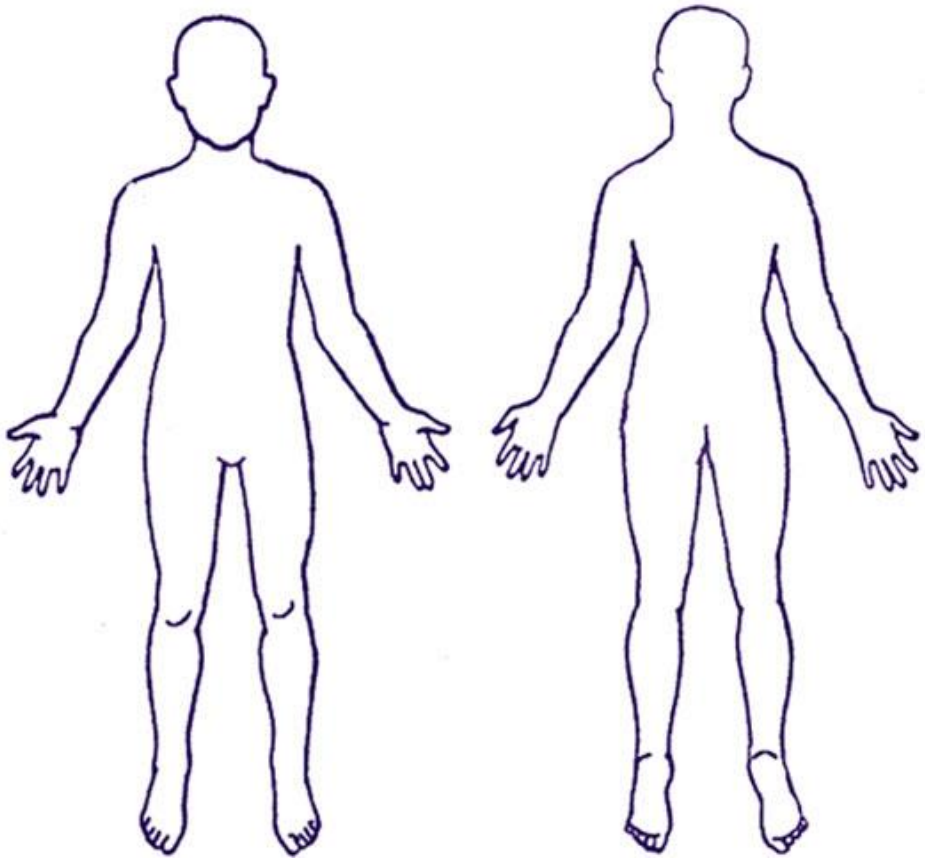
/	English
	## New Patient Questionnaire for newly arrived migrants in the UK
	Everyone has a right to register with a GP. You do not need proof of address, immigration status, ID or an NHS number to register with a GP. This questionnaire is to collect information about your health so that the health professionals at your GP practice can understand what support, treatment and specialist services you may need in accordance with the confidentiality and data sharing policies of the National Health Service. Your GP will not disclose any information you provide for purposes other than your direct care unless: you have consented (e.g. to support medical research); or they are required to do so by law (e.g. to protect other people from serious harm); or because there is an overriding public interest (e.g. you are suffering from a communicable disease). Further information about how your GP will use your information is available from your GP practice. Return your answers to your GP practice.
	## Section one: Personal details
	Full name:
	Address:
	Telephone number:
	Email address:

	Please complete all questions and tick all the answers that apply to you.
	1.1 Date questionnaire completed:
	1.2 Which of the following best describes you? ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
	1.3 Is this the same gender you were given at birth? ☐ No ☐ Yes ☐ Prefer not to say
	1.4 Date of birth: Date_____ Month _____ Year _____
	1.5 Religion: ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish ☐ Muslim ☐ Sikh ☐ Other religion ☐ No religion
	1.6 Marital status: ☐ Married/civil partner ☐ Divorced ☐ Widowed ☐ None of the above
	1.7 Sexual Orientation: ☐ Heterosexual (attracted to the opposite sex) ☐ Homosexual (attracted to the same sex) ☐ Bisexual (attracted to males and females) ☐ Prefer not to say ☐ Other

	1.8 Main spoken language: ☐Albanian ☐Russian ☐Arabic ☐Tigrinya ☐Dari ☐Ukrainian ☐English ☐Urdu ☐Persian ☐Vietnamese ☐Other
	1.9 Second spoken language: ☐Albanian ☐ Russian ☐Arabic ☐Tigrinya ☐Dari ☐Ukrainian ☐English ☐Urdu ☐Persian ☐Vietnamese ☐Other ☐None
	1.10 Do you need an interpreter? ☐No ☐Yes
	1.11 Would you prefer a male or a female interpreter? Please be aware that interpreter availability might mean it is not always possible to meet your preference. ☐Male ☐Female ☐I don't mind
	1.12 Are you able to read in your own language? ☐No ☐Yes ☐I have difficulty reading
	1.13 Are you able to write in your own language? ☐No ☐Yes ☐I have difficulty writing
	1.14 Do you need sign language support? ☐No ☐Yes
	1.15 Please give details of your next of kin and/or someone we can contact in an emergency:

	Next of kin Name: Contact telephone number: Address:
	Emergency contact (if different) Name: Contact telephone number: Address:
	## Section two: Health questions
	2.1 Are you currently feeling unwell or ill? ☐ No ☐ Yes
	2.2 Do you need an urgent help for your health problem? ☐ No ☐ Yes
	2.3 Do you currently have any of the following symptoms? *Please tick all that apply* ☐ Weight loss ☐ Cough ☐ Coughing up blood

	☐ Night sweats ☐ Extreme tiredness ☐ Breathing problems ☐ Fevers ☐ Diarrhoea ☐ Skin complaints or rashes ☐ Blood in your urine ☐ Blood in your stool ☐ Headache ☐ Pain ☐ Low mood ☐ Anxiety ☐ Distressing flashbacks or nightmares ☐ Difficulty sleeping ☐ Feeling like you can't control your thoughts or actions ☐ Feeling that you want to harm yourself or give up on life ☐ Other
	2.4 Please mark on the body image the area(s) where you are experiencing your current health problem(s)



	2.5 Do you have any known health problems that are ongoing? ☐ No ☐ Yes
	2.6 Do you have or have you ever had any of the following? Please tick all that apply ☐ Arthritis ☐ Asthma ☐ Blood disorder ☐ Sickle cell anaemia ☐ Thalassaemia ☐ Cancer ☐ Dental problems ☐ Diabetes ☐ Epilepsy ☐ Eye problems ☐ Heart problems ☐ Hepatitis B ☐ Hepatitis C ☐ HIV or AIDS ☐ High blood pressure ☐ Kidney problems ☐ Liver problems ☐ Long-term lung problem/breathing difficulties ☐ Mental health problems ☐ Low mood/depression ☐ Anxiety ☐ Post-traumatic stress disorder (PTSD) ☐ Previously self-harmed ☐ Attempted suicide ☐ Other ☐ Osteoporosis ☐ Skin disease ☐ Stroke ☐ Thyroid disease ☐ Tuberculosis (TB) ☐ Other
	2.7 Have you ever had any operations / surgery? ☐ No ☐ Yes

	2.8 If you have had an operation / surgery, how long ago was this? ☐ In the last 12 months ☐ 1 – 3 years ago ☐ Over 3 years ago
	2.9 Do you have any physical injuries from war, conflict or torture? ☐ No ☐ Yes
	2.10 Do you have any mental health problems? These could be from war, conflict, torture or being forced to flee your country? ☐ No ☐ Yes
	2.11 Some medical problems can run in families. Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following? Please tick all that apply ☐ Cancer ☐ Diabetes ☐ Depression/Mental health illness ☐ Heart attack ☐ High blood pressure ☐ Stroke ☐ Other
	2.12 Are you on any prescribed medicines? ☐ No ☐ Yes *–please list your prescribed medicines and doses in the box below* ***Please bring any prescriptions or medications to your appointment*** *Name* | *Dose*

	2.13 Are you worried about running out of any these medicines in the next few weeks? ☐No ☐Yes	
	2.14 Do you take any medicines that have not been prescribed by a health professional e.g medicines you have bought at a pharmacy/shop/on the internet or had delivered from overseas? ☐No ☐Yes –*please list medicines and doses in the box below* ***Please bring any medications to your appointment***	
	Name	*Dose*
	2.15 Are you allergic to any medicines? ☐No ☐Yes	
	2.16 Are you allergic to anything else? (e.g. food, insect stings, latex gloves)? ☐No ☐Yes	
	2.17 Do you have any physical disabilities or mobility difficulties? ☐No	

	☐Yes
	2.18 Do you have any sensory impairments? *Please tick all that apply* ☐No ☐Blindness ☐Partial sight loss ☐Full hearing loss ☐Partial hearing loss ☐Smell and/or taste problems
	2.19 Do you have any learning difficulties? ☐No ☐Yes
	2.20 Is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional? ☐No ☐Yes
	## Section three: Lifestyle questions
	3.1 How often do you drink alcohol? ☐Never ☐Monthly or less ☐2-4 times per month ☐2-3 times per week ☐4 or more times per week *There is **1 unit** of alcohol in:*  *½ pint glass of beer*  *1 small glass of wine*

	 *1 single measure of spirits*
	3.2 How many units of alcohol do you drink in a typical day when you are drinking? ☐ 0-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
	3.3 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? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
	3.4 Do you take any drugs that may be harmful to your health e.g. cannabis, cocaine, heroin? ☐ Never ☐ I have quit taking drugs that might be harmful ☐ Yes
	3.5 Do you smoke? ☐ Never ☐ I have quit smoking ☐ Yes ☐ Cigarettes How many per day? _____ How many years have you smoked for? _____ ☐ Tobacco Would you like help to stop smoking?

	☐Yes ☐No
	3.6 Do you chew tobacco? ☐Never ☐I have quit chewing tobacco ☐Yes
	## Section four: Vaccinations
	4.1 Have you had all the childhood vaccinations offered in your country of origin? ***If you have a record of your vaccination history please bring this to your appointment.*** ☐No ☐Yes ☐I don't know
	4.2 Have you been vaccinated against Tuberculosis (TB)? ☐No ☐Yes ☐I don't know
	4.3 Have you been vaccinated against COVID-19? ☐No ☐Yes ☐1 dose ☐2 doses ☐3 doses ☐More than 3 doses ☐I don't know
	## Section five: Questions for female patients only
	5.1 Are you pregnant? ☐No ☐I might be pregnant ☐Yes How many weeks pregnant are you?_____

	5.2 Do you use contraception? ☐ No ☐ Yes What method do you use? ☐ Barrier contraception *e.g. condoms, gel* ☐ Oral contraceptive pill ☐ Copper Coil/Intrauterine device (IUD) ☐ Hormonal coil/Intrauterine System (IUS) *e.g. Mirena* ☐ Contraceptive injection ☐ Contraceptive implant ☐ Other
	5.3 Do you urgently need any contraception? ☐ No ☐ Yes
	5.4 Have you ever had a cervical smear or a smear test? This is a test to check the health of your cervix and help prevent cervical cancer. ☐ No ☐ Yes ☐ I would like to be given more information
	5.5 Have you had a hysterectomy (operation to remove your uterus and cervix)? ☐ No ☐ Yes
	5.6 As a female patient is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional? ☐ No ☐ Yes
	If there is something that you do not feel comfortable sharing in this form and you would like to discuss it with a doctor, please call your GP and book an appointment.