**Patient Questionnaire – Over 16**

**We use this information to understand more about you and make sure we know about any care you are getting, including any medications you take. It is really important that you complete all the form and that we can understand the information so we record it correctly – please complete electronically, sign and scan to us (or bring in) with you registration form, thank you**.

Name       Date of Birth

Address

Telephone Number       E- Mail

### We use text messaging to send notification about appointment reminders, flu clinics, health promotion information, cancellation of clinics, changes in service provision and results. You can opt out of this service at any time by phoning 01224 492828.

**I agree to being contacted by text** …………………………………………………………………………… Signature

Marital Status –  Married  Single  Divorced  Widowed  Separated

Occupation       Are you a professional driver (bus/taxi/lorry etc)  Yes  No

Have you ever served in the Armed Forces  Yes  No

If yes – How long did you serve for?       years What was your job?

What ethnic group do you belong to? (you do not have to tell us but it is helpful if you do)

White  Chinese  Indian  Bangladeshi  Pakastani  Black-African  Black Carribbean

Other, please state

What is your main spoken language?       Do you need an interpreter?  Yes  No

Are you an unpaid carer (looking after a family member, friend or neighbour who needs help)  Yes  No

If yes, would you like us to refer you for advice on the help available for carers  Yes  No

**Medical Information**

**Previous Serious Illnesses – Have you suffered from any of the following –**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes Date** | **No** |  | **Yes Date** | **No** |
| **Alcohol Problems** |  |  | **Asthma** |  |  |
| **Atrial Fibrilation** |  |  | **Cancer** |  |  |
| **Chronic Kidney Disease** |  |  | **Dementia** |  |  |
| **Depression** |  |  | **Drug Addiction** |  |  |
| **Diabetes** |  |  | **Epilepsy** |  |  |
| **Fractures** |  |  | **Heart Problems** |  |  |
| **Hypertension** |  |  | **Learning Difficulties** |  |  |
| **Osteoporosis** |  |  | **Thyroid** |  |  |

**Any other significant medical history?**  Yes  No If yes – please list -

Condition       Date

Condition       Date

Condition       Date

Condition       Date

**Have you had any pregnancies?**  Yes  No If yes – please note the date/s (MM/YY)

**Have you had any operations?**  Yes  No If yes – please list –

Operation       Date

Operation       Date

Operation       Date

Please provide a list of any medications you are taking at the moment – we will need to see confirmation of these being prescribed by your previous GP (summary from previous GP or pictures of prescribed medication)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Strength** | **How often taken** | **Reason for taking** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Do you have any drug allergies**  Yes  No If yes, please list –

Do you use contraception?  Yes  No If yes, please tick which –

Combined Oral Contraceptive Pill  Progesterone Only Pill  Depo Provera  Implanon

Coil  Condoms  Other

Are you a smoker?  Yes – number per day ……..  Ex-smoker – date stopped …………….  Never smoked

Alcohol - please estimate your alcohol intake per week (1 unit = half pint beer/ 125ml glass wine / 1 measure spirit)

Amount of alcohol per week

How tall are you?       How much do you weigh?

Date Form Completed       Signature ………………………………………………………………………………………………..