**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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|  |  |  |  |
|  |  |  |  |
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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 ………………………………………………………………………………………………..