Grove Medical Centre



 **New Patient Health Questionnaire for Adults (14 years and Over)**

 **Personal Details** Title:…………... First Names …………………………………………………

Surname …………………………….…….……….. Date of Birth ………………………………

Occupation ………………………………………………………………………………….

Home Address…………………………………………………………………………………………

Postcode …………………………………………………….

Home Landline Tel .................................................Work TEl.............................

Mobile ………………………………………………………Email ……………………………………………………………………

* What is your preferred written method of communication? (**please circle one**)

SMS Email Letter

**Shared mobile numbers are not advised as there is a risk that individuals who share mobile phones will receive messages meant for others**.

Do you give consent for the surgery to sent text messages - YES NO

 **First Language** ……………………………………………. **English speaker?............................**

Ethnic Group - **MUST BE FILLED IN PLEASE**

|  |  |  |  |
| --- | --- | --- | --- |
| White British |  | White other |  |
| Asian or Asian British-Bangladeshi |  | Asian/Asian British- Pakistani |  |
| Asian or Asian British-Indian |  | Asian or Asian British-Other |  |
| Black Caribbean |  | Black African |  |
| Black Other |  | Other –please state |  |

 **Medical Information Weight ……………………………kg Height …………………………….m**

**YES I WOULD LIKE TO BECOME INVOLVED WITH THE Surgery Patient Participation Group (tick box)**

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems), including the year they took place:

 **Have you ever suffered from the following?**

(Please specify year of diagnosis if known)

 Epilepsy Blindness/Glaucoma Heart Attack Diabetes COPD

4+ times per week

4+ times per week

4+ times per week

4+ times per week

High Blood Pressure Asthma Stroke/TIA Cancer Eczema

4+ times per week

4+ times per week

4+ times per week

4+ times per week

4+ times per week

Hay Fever

4+ times per week

Please list any medications taken and the amount

 Are you allergic to any medicines, and if so which?.......................................................................

Have you ever suffered from the following: **Depression /Anxiety/ OCD /PTSD/ Bipolar Disorder Other** (please specify)………………………………………………………………………..

Are you receiving any treatment or therapy? (If yes, please specify details of care and when this occurred)

Have you ever refused treatment/screening of any kind? If so, what and when?

Are you registered disabled? Yes No

4+ times per week

4+ times per week

 Please give detail:…………………………………………………………………………………………………………………………… ………………………………………………………………………………………………………………………………………………………

**Bp Reading** – (if you have a blood pressure machine at home)………………………………………………

**Smoking**

Do you smoke? YES NO

 If ‘No’ have you ever smoked? Yes No

If ‘Yes’, when did you quit? …………………………………………

 If ‘Yes’ how many cigarettes/ounces of tobacco do you smoke each day? …………………………………….

 Would you like advice on giving up smoking? Yes No

**Alcohol UNITS** *2 units = 1 pint beer or 1 glass of wine(175mls)*

 *1 unit= single measure of spirits*

 *1.5 units= alcopop or a can of Lager*

 *9 units= 1 bottle of wine*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Your Score** |
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4+ times a week |   |
| 2. How many drinks containing alcohol on a typical day when you are drinking? | 1-2 (score 0) | 3-4 (score 1) | 5-6 (score 2) | 7-9 (score 3) | 10+ (score 4) |   |
| 3. How often do you have six or more drinks in one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
|  |  |  |  |  |  |  |
| **If your total score on questions 1-3 is more than 5 please carry on with the next questions** |  |
|  |  |  |  |  |  |  |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
| 6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |   |
| 9. Have you or someone else been injured because of your drinking? | No |   | Yes, but not in the last year |   | Yes, during the last year |   |
| 10. Has a relative , friend, doctor or other health care woerker been concerned about you drinking or suggested you cut down? | NO |   | Yes, but not in the last year |   | Yes, during the last year |   |

**If your score is above 8 Please make an appointment to discuss your alcohol use or *www.nhs.uk/Livewell/alcohol***

**Carers**

Do you have a carer? Yes No

4+ times per week

4+ times per week

 If yes, please give details………………………………………………..

Are you a carer? Yes No

4+ times per week

4+ times per week

If yes, please give details………………………………………………..

**Has Anyone in your family ever suffered from:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HIV/AIDS | YES | NO | Family member: | Age of diagnosis: |
| TB |  |  | Family member:  | Age of diagnosis |
| Hepatitis B |  |  | Family member: | Age of diagnosis |
| Diabetes |  |  | Family member: | Age of diagnosis |
| Heart Disease |  |  | Family member:  | Age of diagnosis |
| Stroke |  |  | Family member:  | Age of diagnosis |
| High Blood Pressure |  |  | Family member:  | Age of diagnosis |
| Asthma |  |  | Family member:  | Age of diagnosis |
| Cancer |  |  | Family member: | Age of diagnosis |

**Military History**

Are you currently in the military? Yes No

4+ times per week

4+ times per week

Are you a military veteran? Yes No

4+ times per week

4+ times per week

**Will**

Do you hold a Living Will? Yes No (*A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)*

4+ times per week

4+ times per week

**Women**

Have you ever had a cervical smear? Yes No

4+ times per week

4+ times per week

 If Yes, please state when, where and any known results:……………………………………………………………………

………………………………………………………………………………………………………………………………………………………

**IMPORTANT –NEW PATIENT HEALTH CHECK**

**ALL NEW PATIENTS ARE OFFERED A NEW PATIENT HEALTH CHECK. HOWEVER, IF YOU ARE DUE YOUR USUAL YEARLY HEALTH CHECK DUE TO BEING UNDER CHRONIC DISEASE REGISTERS,(diabetes, hypertension, heart, asthma,) THIS WILL BE DONE TOGETHER AT THE TIME WE CALL YOU.**

Are you seen yearly?..........................(yes/no). (**To place on list to book a NEW PATIENT HEALTH CHECK if NO)**

If YOU ARE NOT UNDER YEARLY HEALTH CHECKS we will organise a new patient health check in the next few weeks.

…………………………………………………………………………………………………………………………………………………………

If **you do not wish** to have a New Patient Health Check please sign the **dissent declaration below:**

**Patient Name** **.………………………………………………… Patient date of birth**…………………………………..

I **do not** wish to have the NHS Health Check.

**Signature of patient** **……………………………………… Date**………………………………………

**Summary Care Record**

The **Summary Care Record** has basic information that is useful for NHS clinicians. It shows if you have allergies and it lists your medications. 98% of people have this. By including additional information, this will add your illnesses and any health problems, vaccinations, operations and information on how you would like to be treated.

Your record can only be seen by staff currently involved in your direct care and have a need to see it.

Yes, I am happy for additional information to be added to my summary care record, this means healthcare staff treating me can see a summary of my medical history in addition to my medications and allergies.

**Please Tick and Sign**

**Name…………………………………………………………. Date of Birth………………………………………….**

**SIGNATURE………………………………………………………………………………………..**

If you are filling in this form on behalf of another person, please ensure that you fill in their details above, sign the form above and then provide your details below.

,,

**Name………………………………………………………..**  …. Parent Legal Guardian Power of Attorney

Cervical Screening

Are you under the cervical screening recall programme?

Yes NO Please circle

Date of last smear………………………………………………..

If you are aged between 25 and 64 years old you are entitled to cervical screening. **For England and Northern Ireland**– you get an invite every 3 years if you are aged 25 to 49. After that, you get an invite every 5 years until the age of 64.

Cervical screening is for anyone within this age range who has a cervix, such as trans men and non-binary people. You can talk to your GP about this Or please request an appointment below.