

HIGHTOWN SURGERY

PATIENT RECORD QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical records.

Surname..... M F DOB:

Forenames..... Maiden name.....

Mr Mrs Ms Miss Other Single Partnered Married Divorced Widowed

NHS Number.....

Address.....
..... Postcode.....

Contact Details.

Home..... Work.....

Mobile..... Email Address.....

Occupation (Last /Main).....

Next of Kin(or in an emergency)

Name..... Relationship to this person.....

Their address (If different to your own).....
..... Telephone Number.....

Are you a Carer Yes No

Medical History
List all illnesses or operations, major accidents and hospital admissions. E.g. Hysterectomy

Year	Illness/operation
.....
.....
.....
.....
.....

List all medicines you regularly use(tablets,creams,inhalers,patches,whether prescribed or bought over the counter)

.....
.....

Family History

Have you a family history of:

Heart Disease	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Other	<input type="checkbox"/>

.....

Which relative..... Age of onset.....

Which relative..... Age of onset.....

Lifestyle

Any medication allergies Yes Name..... No

Any other allergies or intolerances e.g. Food or Hay Fever Yes Name No

What is your height What is your weight

Any special diet Yes Name..... No

Do you exercise Yes How No

Do you drink alcohol Yes Units per week..... No

Do you smoke Yes No per day Ex smoker Year stopped No

If you would like smoking cessation advice please make an appointment with the Practice Nurse.

Has your blood pressure been measured in the last 2 years Yes No

If NO can existing patients please make an appointment with the Practice nurse.

Women only

Date of last cervical smear Result Normal Abnormal Never had a smear

Date of rubella vaccination (MMR/MR) Never had vaccination

Have you had a hysterectomy Yes Reason..... No

Have you ever been pregnant Yes No of children Miscarriages Abortions..... No

Do you use contraception Yes Which method No

Children Only (Parents should fill in a separate questionnaire for each child under 12)

Mothers name..... Fathers name.....

Birth details

Hospital and city..... Was this birth Full term Premature Induced

Was the Delivery Normal Forceps Caesarean Birth weight Breast Fed Y How long.....

Immunisation	Recommended Age	Date given
1 st DTP/Hib/Polio	2 months old	
1 st Pneumococcal conjugate vaccine	2 months old	
2 nd DTP/Hib/Polio	3 months old	
1 st Men C	3 months old	
3 rd DTP/Hib/Polio	4 months old	
2 nd Men C	4 months old	
2 nd Pneumococcal conjugate vaccine	4 months old	
3 rd Men C	12 months old	
Hib booster	12 months old	
MMR	13 months old	
3 rd Pneumococcal conjugate vaccine	13 months old	
DTP/Polio Booster	3 years 5 months- 5 years	
MMR Booster	3 years 5 months- 5 years	
BCG		
Other		

This questionnaire follows the recommendations of the Commission for Racial equality and complies with the Race Relations Act

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Name.....

Date of birth.....

WHITE

WHITE BRITISH

DECLINE

WHITE IRISH

OTHER WHITE BACKGROUND

Main Language spoken:.....

MIXED

MIXED WHITE AND BLACK CARIBBEAN

MIXED WHITE AND BLACK AFRICAN

WHITE AND ASIAN

OTHER MIXED BACKGROUND

ASIAN OR ASIAN BRITISH

INDIAN

PAKISTANI

BANGLADESHI

OTHER ASIAN BACKGROUND

BLACK OR BLACK BRITISH

CARIBBEAN

AFRICAN

OTHER BLACK BACKGROUND

CHINESE OR OTHER ETHNIC GROUP

CHINESE

OTHER

I am happy to be contacted by SMS text message

YES/NO

Data Protection.

Your records will be safe with us. If other organisations ask for your details or a report we will always check that you have given them your signed consent.

I have read the practice leaflet and agree to comply with the services offered to me.

Signed.....

Date

FAST QUESTIONNAIRE

Name:

DOB:

For the following questions please tick the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
WOMEN: How often do you have SIX or more drinks on one occasion?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
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
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, on one occasion	Yes, on more than one occasion		
	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 4		

Total for Each Column:

Total: _____