HOLBROOK AND SHOTLEY SURGERY
HEALTH QUESTIONNAIRE

Mr/Mrs/Miss/Ms/Other..................................... Date of Birth ....../....../.........

Surname .... Forename ....

Address ....

.... Post Code ....

Home Tel .... Work .... Mobile ....

Email ....

Marital Status Single / married / co-habiting / divorced / widowed / other ....

Religion .... Occupation ....

Ethnicity .... First Language.................... English Speaking **YES/NO**

NEXT OF KIN DETAILS

Name .... Relationship .... Tel ....

Address ....

MEDICAL HISTORY ....

REPEAT MEDICATION REQUIRED YES/NO DETAILS...
(Please note that if you are on any repeat medication, you will need to see a GP with your previous medication list, before you need you next prescription. Your new medication list will then be added to your records. Failure to do this could result in a break in your medication)

FAMILY HISTORY (immediate family only)

Any important family illnesses or diagnoses ....

SMOKING STATUS (please delete as applicable)

Smoker **YES/NO** How many per day .... Ex-smoker **YES/NO** Never smoked **YES/NO**
If you are a smoker, would like smoking cessation advice **YES/NO**

Height .... Weight ....

EXERCISE STATUS

How often do you exercise? Number of times a week ...... Types of exercise ....

ALCOHOL STATUS

Alcohol units per week ……. (1 unit = ½ pint, 1 glass of wine, 1 pub measure of spirits)

QUESTIONS	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
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	
					TOTAL	

CARERS

Do you have a carer? **YES/NO**
If YES would you like them to deal with any health affairs on your behalf? **YES / NO**
Please state carers name / address / phone number
………

Please sign below if you wish us to disclose information about your health to your Carer

Signed ……………………………………. Date ………………………………….

Are you a carer? **YES/NO** If YES do you need carer's support? **YES/NO**
In the case of a child or young person (under 18) in care or privately fostered, who has parental responsibility and who is the main carer?
Name ……………………………… Relationship ……………………………… Tel ………………………………
Address ………………………………………………………………………………………………

SPECIFIC NEEDS

Have you nominated someone to speak on your behalf? (e.g. a person who has Power of Attorney)
YES/NO (If "Yes", please state their name / address / phone number ……………………………………………
………

Do you have any special needs/disabilities we should be aware of?
If yes please specify ………………………………………………………………………………………………………

PLEASE PROVIDE TWO SEPARATE FORMS OF IDENTIFICATION. ADDRESS CONFIRMATION AND PHOTO ID

For office use only
Form accepted by ……………… (initials)
Type of confirmation seen (this must be official and not confirmation of an online purchase for example)

- ☐ Driving licence
- ☐ Utility bill
- ☐ Bank/credit card statement
- ☐ Other
- ☐ Informed patient of registered GP

PATIENT PARTICIPATION GROUP

The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. Are interested in getting involved **YES/NO**

ELECTRONIC DATA SHARING MODULE

Patients can choose to permit or restrict access to the information entered into their record at each organisation that accesses their record via the same clinical system. Examples of these organisations are the District Nursing Team, Health Visitors, Podiatry Clinic, Hospital based clinics, Community based clinics. The patient will be asked to give their record sharing consent at each organisation at which they receive care. The patient's consent can be changed at any time.

SHARING OUT

Do you consent to the sharing of data recorded here with any other organisations that may care for you?

☐ Yes – share data with other organisations
☐ No – do not share any data recorded here

SHARING IN

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make the data shareable?

☐ Consent given
☐ Consent refused

SMS CONSENT

I consent to appointment confirmations / reminders / test results etc being sent to me by SMS text messaging.

☐ Consent given
☐ Consent refused

EMAILS

Where an email address has been provided, I consent to receive the Practice Newsletter

☐ Consent given
☐ Consent refused

SUMMARY CARE RECORD

☐ Consent given. If you want a record you do not need to do anything further, one will be created for you when you register with your GP practice. You will be asked this information each time your register with a new GP practice.

☐ Consent refused. You will need to fill in the Summary Care Record opt out form, within 2 weeks of registration. The form is available from reception or from our website. You MUST do this even if you have already completed a form at your previous GP practice. Failure to submit the opt out form within the timescale, will result in giving your express consent.

……………………………………………… ……………………………………………… …./…./….

Your name (capitals) **Your signature** **Date**