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	☐	High Blood Pressure	☐	Diabetes	☐	High Cholesterol ☐
	Stroke	☐	Cancer	☐	Osteoporosis	☐	Other ☐ ……

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
1st DTP/Hib/Polio	2 months old	
1st Pneumococcal conjugate vaccine	2 months old	
2nd DTP/Hib/Polio	3 months old	
1st Men C	3 months old	
3rd DTP/Hib/Polio	4 months old	
2nd Men C	4 months old	
2nd Pneumococcal conjugate vaccine	4 months old	
3rd Men C	12 months old	
Hib booster	12 months old	
MMR	13 months old	
3rd 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 ☐

WHITE IRISH ☐

OTHER WHITE BACKGROUND ☐

DECLINE ☐

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? WOMEN: How often do you have SIX or more drinks on one occasion?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **4**
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **4**
How often during the last year have you failed to do what was normally expected of you because of drinking?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **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** ☐ **0**	**Yes, on one occasion** ☐ **2**	**Yes, on more than one occasion** ☐ **4**		

Total for Each Column:

Total: ___