The Caversham Group Practice

HEALTH QUESTIONNAIRE FOR NEW PATIENTS OVER 16 YEARS

Welcome to the Caversham Practice. Please help us by filling in as much of this questionnaire as possible. If you have any questions, or you need help filling this form in, please ask at reception. If you run out of space, ask the receptionist for more paper.

About You

Name:_____ Date of birth:____(dd)____(mm)_____(yyyy)

Address:_____

Postcode:_____ Telephone (home) _____Telephone (work) _____

Mobile: _____ Email: _____

Would you like to be part of our patient participation group? – We occasionally send short surveys regarding practice issues to these people (via email where possible). Please tick here if you would like to take part ❑

Your town and country of birth: (If London what borough?) _____

Status (single/married/co-habiting/separated/divorced/widowed) _____Your sex: (male/female) _____

Employment Status: EMPLOYED ❑SELF EMPLOYED ❑ (what is your job?)_____

UNEMPLOYED❑ LONGTERM SICKNESS ❑ (length of time) _____ (months/years);

RETIRED ❑ IN FULL-TIME EDUCATION ❑

Your Household

Do you live alone? YES ❑ NO ❑.

If you live alone, who can we contact if there is an urgent need to? Name _____
Contact number _____ Relationship to you: _____

If you share a household with others who are registered here, please give details:

Name_____ Date of birth____(dd)____(mm)____(yyyy). Relationship to you:_____
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Type of accommodation: PRIVATE RENTED ❑; COUNCIL/HOUSING ASS ❑; OWNER OCCUPIED ❑: HOSTEL ❑

A carer is a family member, neighbour or friend who spends time supporting or looking after someone who is unable to manage on their own because they have a disability, a long term illness, a mental health or substance misuse problems or they may be frail

Are you a carer? YES ❑ NO ❑. Do you have a carer? YES ❑ NO ❑.

If yes to above who do you care for / or who cares for you? Name and contact number:

_____

Staff only: Staff initials ☐

Proof of ID shown ❑ Proof of address shown ❑ BP: /

Your Health

You must complete each question below by circling either yes or no.

Have you ever had a heart attack?	**Yes**	**No**
Do you have a pace maker?	**Yes**	**No**
Have you ever had heart pain (angina)?	**Yes**	**No**
Have you ever had a Stroke?	**Yes**	**No**
Are you taking medication for high blood pressure?	**Yes**	**No**
Do you have asthma? If yes which year was it diagnosed in?	**Yes**	**No**
Do you use inhalers?	**Yes**	**No**
Do you have COPD? (chronic bronchitis, emphysemas, bronchiectasis)	**Yes**	**No**
Do you have Diabetes?	**Yes**	**No**
Do you have Epilepsy?	**Yes**	**No**
Are you taking Thyroxine?	**Yes**	**No**
Do you or have you ever had any Cancers?	**Yes**	**No**
Have you ever had any mental health problems?	**Yes**	**No**

If you ticked yes to any of the above you will be offered a new patient check by the nurses.

Regular medicines or treatment either prescribed or bought 'over the counter'? (Please state dosage, if known)

_____
_____
_____
_____

Are you allergic to any drugs? Please give name(s) of drug and nature of reaction _____
_____

How tall are you? _____ * How much do you weigh? _____ *

Do you smoke? YES ❑ (How many per average day?)_____; EX-SMOKER ❑ (How many per average day did you smoke?)_____ (date you gave up)_____(mm)_____(yyyy); NEVER SMOKED ❑

<u>Smokers</u> – you know that smoking is bad for your health and the health of those around you. We offer smoking cessation advice and treatment. Ask at reception tomake an appointment for our specialist stop smoking clinic.

Alcohol:

How many units do you drink in an average week? _____

1 unit = 1 glass of win, ½ pint beer, 1 pub measure of spirits

Please circle the option that best describes you drinking habits:

1. How often do you have a drink containing alcohol?

Never (0)	Monthly or less (1)	2 to 3 times a month (2)	2 to 3 times a week (3)	4 or more times a week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)

3. How often do you have six or more units on one occasion?

Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

Add to work out your total score: _____

If you score 4 or more and you are female or 5 or more and you are male your health may be at risk from the amount you drink. Ask for a sensible drinking pack at reception or you can make an appointment with the sensible drinking advisor, the practice health trainer, your doctor or nurse to discuss this further.

(For office use only: please use tool in prompts to record results or AUDIT-C If score over 4 for women or 5 for men add codes: .136S & 9k1A)

For office use record alcohol consumption in units using code .136

Your family's health

We should like to know if there is any history of certain illnesses within your close family (your parents, brother/sisters, or children.)

Is there a family history of heart attack or angina? YES ❑ NO ❑

If YES, were they aged under 60 at the time? YES ❑ NO ❑

Is there a family history of stroke? YES ❑ NO ❑

Is there a family history of high blood pressure? YES ❑ NO ❑

Is there a family history of diabetes? YES ❑ NO ❑

if yes and you are over 40 please ask for a blood sugar test if you have not had one in the last year

Is there a family history of glaucoma? YES ❑ NO ❑

Is there a family history of epilepsy? YES ❑ NO ❑

Does anyone have high cholesterol? YES ❑ NO ❑

Is there a family history of cancer YES ❑ NO ❑ what Type(s)?_____

Is there a family history of asthma? YES ❑ NO ❑

WOMAN ONLY

In order to register with the practice we need the questions below answered.
This information is vital.
If you do not have dates to hand your previous GP should have it on record.
If you have had a smear test out of this country then you will need to have one here as we will not have the result on record.

Have you ever had a cervical smear test? YES ❑ NO ❑ **if yes when?**_____

Was it normal? YES ❑ NO ❑ If 'No' what was the result? _____

Do you have a written copy of the result? YES ❑ NO ❑ If 'yes' please give us a copy

Where was it performed? GP Surgery/Family planning clinic/Hospital/Private Clinic/Abroad

Have you ever had a mammogram? YES ❑ NO ❑ If 'yes' was it normal? YES ❑ NO ❑

If 'no' what was the result? _____

Have you ever had a positive blood test for Rubella antibodies (German measles)?

YES ❑ NO ❑ Don't know ❑ If 'yes' please give date _____

Have you had a hysterectomy? YES ❑ NO ❑

If 'yes' When? _____

Have you been sterilized? YES ❑ NO ❑

Do you use any form of contraception? YES ❑ NO ❑ If 'yes' which one?
Pill /condoms / cap / coil / implant / injection / natural

If you take the contraceptive pill, which one do you take? _____

If you have a coil fitted which one and when was it fitted? _____

Thank you.
Please make sure a form is completed for *each member of your household* who is registering with the Practice. When you have finished, please hand the forms back to the receptionist.