**The Caversham Group Practice**

**HEALTH QUESTIONNAIRE FOR NEW PATIENTS OVER 16 YEARS**

Please help us by filling in as much of this questionnaire as possible. We highly recommend you sign up to access our online services via our website: www.cavershamgrouppractice.co.uk. If you need help filling this form in or would like access to our online services please ask at reception.

## **About You**

**Name:**

**Date of birth:**

**Address:**

**Post Code:**

**Home telephone number:**

**Work telephone number:**

**Mobile:**

**Email:**

## **Communication support needs**

**Do you have any information and communication support needs?** For example, would you like information in **Large Print** or **Easy Read** format? Do you use a hearing aid or communicate in **British Sign Language**? Do you need a language interpreter?

**Please tell us your preferences:**

**My GP can share my communication needs and preferences with other health services.**

* Yes
* No

**Do you have a disability?**

* **Yes**
* **No**

**If yes, how would you describe your disability?**

**Use surgery Pod B/P:\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_**

**Staff Initials:\_\_\_\_\_\_\_**

**Would you like to be part of our patient participation group?**

* **Yes**
* **No**

**What is your occupation?**

* Employed
* Self employed
* Unemployed
* Retired
* Unemployed
* In full time education

**Your Household:**

**What is your type of accommodation:**

* **Privately rented**
* **Council/housing association**
* **Owner occupied**
* **Living with friends/relatives**
* **B&B**
* **Hostel/night shelter**
* **Squatting**
* **Rough sleeper**
* **No Fixed Abode**

**Do you live alone?**

* **Yes**
* **No**

**Next of kin details:**

**If there is an emergency, who should we contact on your behalf?**

**Name:**

**Relationship to you:**

**Contact number:**

**If you share a household with others who are registered here, please give details (Only applicable to families):**

**Name:**

**Date of birth:**

**Relationship to you:**

**Name:**

**Date of birth:**

**Relationship to you:**

**Name:**

**Date of birth:**

**Relationship to you:**

**Name:**

**Date of birth:**

**Relationship to you:**

**Name:**

**Date of birth:**

**Relationship to you:**

**Carers**

**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 problem or they may be frail.**

**Are you a carer?**

* Yes
* No

**If yes, who are you a Carer for?**

**Do you have a Carer?**

* Yes
* No

**If yes, what is your Carer’s name and contact information?**

## **Your Health**

**Please 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?**

* **Yes (if yes – which year diagnosed?)**
* **No**

**Do you use any inhalers?**

* **Yes**
* **No**

**Do you have diabetes?**

* **Yes (if yes – which year diagnosed?)**
* **No**

**Do you have epilepsy?**

* **Yes (if yes – when was you last fit?)**
* **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**

**Do you take any regular medicine or treatment either prescribed or bought over the counter?**

* **Yes**
* **No**

**If yes, please tell us what you take and the dosage.**

**Are you allergic to any drugs?**

* **Yes**
* **No**

**If yes, please tell us the name and nature of reaction.**

**Do you smoke?**

* **Yes**
* **No**

**If yes, how may per day on average?**

**Are you an ex-smoker?**

* Yes
* No

**If yes, how many did you smoke and when did you give up?**

**Would you like help to quit smoking?**

We offer advice and treatment. Please ask at reception for an appointment with our health care assistant.

**How often do you have a drink that contains alcohol?**

* Never (0)
* Monthly or less (1)
* 2-4 times per month (2)
* 2-3 times per week (3)
* 4+ times per week (4)

**How many units of alcohol do you have on a typical day when you are drinking?**

**1 Unit = 1 glass of wine or half a pint of beer or 1 pub measure of spirits**

* 1-2 (score 0)
* 3-4 (score 1)
* 5-6 (score 2)
* 7-9 (score 3)
* 10+ (score 4)

**How often do you have 6 or more units on one occasion?**

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

**TOTAL SCORE =**

**If you score 3 or more, your health may be at risk from the amount you drink.**

**We have an alcohol support worker based at the practice. If you would like to see this person please ask at reception.**

## **Your family’s health**

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

* **Heart attack**
	+ Yes
	+ No
* **Stroke**
	+ Yes
	+ No
* **Diabetes**
	+ Yes
	+ No
* **High blood pressure**
	+ Yes
	+ No
* **Asthma**
	+ Yes
	+ No
* **Glaucoma**
	+ Yes
	+ No
* **High cholesterol**
	+ Yes
	+ No
* **Cancer**
	+ Yes
	+ No
* **Epilepsy**
	+ Yes
	+ No

## **Women only**

**Have you ever had a cervical smear test?**

* **Yes (if yes when?)**
* **No**

**Was it normal?**

* **Yes**
* **No (what was the result?)**

**Have you had a hysterectomy?**

* **Yes (if yes when?)**
* **No**

## **Ethnic Group**

**Please tick below which best describes your ethnicity:**

* White British
* White Irish
* Any other white background
* Pakistani or British Pakistani
* Bangladeshi or British Bangladeshi
* Indian or British Indian
* Any other Asian background
* Mixed White & Black Caribbean
* Mixed White & Black African
* Mixed White & Asian
* Any other mixed background
* Black or Black British, Caribbean
* Black or Black British, African
* Any other Black background
* Chinese
* Any other ethnic group

**Spoken Language**

**Please tell us your preferred spoken language**

**Do you need an interpreter?**

* **Yes**
* **No**

## **NHS Organ Donor registration**

**I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the options that apply.**

* Any of my organs and tissue or
* Kidneys
* Heart
* Liver
* Corneas
* Lungs
* Pancreas
* Any part of my body

**Signature confirming my agreement to organ/tissue donation**

**Date:**

**For more information, please ask at reception for an information leaflet or visit the website**

**www.uktransplant.org.uk, or call 0300 123 23 23.**

## **NHS Blood Donor registration**

**I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.**

**Have you given blood in the last 3 years?**

* Yes
* No

**Signature confirming consent to inclusion on the NHS Blood Donor Register**

**Date:**

**For more information, please ask for the leaflet on joining the NHS Blood Donor Register**

**My preferred address for donation is:** (only if different from above, e.g. your place of work)

**Postcode:**

## **Data sharing**

**Camden Integrated Digital Record**

Camden Integrated Digital Record (CIDR), enables your Camden care providers to view the relevant information about the care you receive, and so give you the best possible care.

I want to opt in to CIDR so Camden care providers can see my records when they are treating me.

* Yes
* No

**Summary Care Record**

If you have a Summary Care Record your health care providers can view information about your medical needs when you’re admitted to hospital, when treating you in an emergency, or when your practice is closed. The information they can see is your:

* current medication
* bad reactions to medicines
* allergies

I want to have a Summary Care Record.

* Yes
* No

**Care.data**

Care.data aims to make increased use of information from medical records with the intention of imporoving healthcare through research.

I want my medical record to be part of Care.data

* Yes
* No – I do not want my personal confidential data to leave the Health and Social Care Information Centre

OR

* No – I do not want my personal confidential data to leave the GP practice

**Name**

**Date of birth**

**Signature of Patient**

**Signature on behalf of Patient**

**Date**