CRAWLEY DOWN HEALTH CENTRE PATIENT QUESTIONNAIRE

In order to be fully registered with the Practice, please complete and return this confidential health questionnaire and leave at the desk ready for your first consultation.

PLEASE COMPLETE IN CAPITAL LETTERS (Including email address)

Surname	**First Name(s)**	**Title** (please circle) Mr Mrs Miss Ms Dr Other _____

Marital Status (Please circle) SINGLE MARRIED PARTNER SEPARATED DIVORCED WIDOWED

Address **Postcode**

Telephone

Mobile Number

Email address (in capitals)

Date of Birth **Town & Country of Birth**

If you have given a **mobile number**, tick ☐ if you do **NOT** want to receive appointment reminders by text.
If you have given an **email address**, tick ☐ if you do **NOT** want to receive appointment reminders by email.

Only enter If you do not wish to receive reminders and health information via email please ☐

Next of Kin Name / Contact

I WOULD DESCRIBE MY ETHNIC ORIGIN AS FOLLOWS:

Asian or Asian British
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background

Black or Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other Black background

Mixed
- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed background

White
- ☐ British
- ☐ Irish
- ☐ Any other White background

Other Ethnic Group
- ☐ Chinese
- ☐ Any other ethnic group

- ☐ I do not wish to disclose my ethnic background

If you are an asylum seeker or refugee, please tick the box as we will provide you with a specific New Patient Health Check ☐

PTO…

If you have had any of the following, please tick:

☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Gout
☐ Asthma	☐ Epilepsy	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Tuberculosis	☐ Migraine	☐ Multiple Sclerosis
☐ Ulcer (*please state type)*			

Have you had any other serious illness / operations / accident? (give years):

Present medication:

Are you allergic to:

Medicines (state which):

Other:

Height* **Weight***

To be done at visit

Last Cervical Smear (same as "PAP Smear") if applicable

Date Result: Normal ☐ Abnormal ☐ Where was it done?

Exercise: Do you take regular exercise? Yes ☐ No ☐ If yes, how often?

Smoking status?

Never smoked ☐

Smoker Cigarettes per day ☐ Cigars / day ☐ Tobacco ☐ oz per day

Ex smoker Yes ☐ in which year did you stop ☐

As research proves that smoking can seriously affect your health, we recommend that you try to give up. We offer a Stop Smoking Clinic at the Surgery to support you and can prescribe nicotine replacement or other medication to aid smoking cessation.
Please tick this box if you would like an appointment. ☐

Family History: (*Please Tick)*

If one member of your family has had one of more of the conditions below, (please tick)

☐ Heart Disease and, if so, were they: ☐ Under 60 ☐ 60 or over

☐ Cancer and, if so, what type:

☐ Diabetes ☐ Angina ☐ Asthma

☐ Stroke ☐ Osteoporosis ☐ High Blood Pressure

Relationship to you (tick one) ☐ Mother, ☐ Father, ☐ Sibling, ☐ or child ☐

Information on alcohol consumption:

Questions	Alcohol scoring system 0	1	2	3	4	Your Score (Leave)
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Please use this space for anything else you wish the surgery to be aware of (continue on a blank page)

Do you have additional communication needs? Yes ☐ No ☐

If yes, please select from the following:-

An Interpreter ☐

Large Print ☐

Braille ☐

Easy Read ☐

Via Email ☐

British Sign Language ☐

Do you have any disabilities that it would help us be aware of?

If you have additional communication needs as a result of a disability or impairment of any kind such as visual, hearing or cognitive impairment, please provide information on how we can help meet your needs.

Carers: Do you need/have anyone who looks after you or your daily needs as a carer?

Yes ☐ No ☐

Do you care for anyone else?

Yes ☐ No ☐

Signature Date

Thank you for completing this questionnaire. The information you provide will be held on our computer system. We are regulated by the Data Protection Act 1988. If you are over 16, please be aware that we are unable to leave messages or divulge information to other family members/friends without your consent.

CONSENT: I give consent for the Practice to leave messages on the contact details provided?

Yes ☐ No ☐

CONSENT: I give consent for the Practice to discuss results, medication and any aspects with the following family member/other named third party

Yes ☐ No ☐

Contacts Name: Telephone No:

Signature Date:

The Summary Care Record is a copy of key information held in your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you - when you need unplanned care or when your GP practice is closed. The availability of Summary Care Records will improve the safety and quality of your care, whenever or wherever you need it, anywhere in England, as they can reference key information that otherwise would not be available to them

I agree to the uploading of my Summary Care Records

Signed Dated:

I DO NOT Agree to the uploading of my Summary Care Records

Signed Dated: