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)

Next of Kin Name / Relationship

Their contact details	**Address if different from your own**

I WOULD DESCRIBE MY ETHNIC ORIGIN AS FOLLOWS:

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

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

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

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

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

☐ I do not wish to disclose my ethnic background

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?

If yes, how often?

Exercise: Do you take regular exercise? Yes ☐ No ☐

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	

Do you have additional communication needs? Yes ☐ No ☐

If yes, please select from the following

An Interpreter ☐ Easy Read ☐ Large Print ☐

Braille ☐ Via E-mail ☐ British Sign Language ☐

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

If you have any 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 ☐

General Data Protection Regulation 2018

To enable us to communicate with you and in accordance with the General Data Protection Regulation 2018 the practice requires written consent from any patient to use your personal contact details for the purposes of your medical care. We would like your consent to leave messages in the various formats and would ask that you tick the boxes below to indicate the communication methods you would prefer.

By ticking the boxes we would ask you to consider whether those around you may be able to hear or access your message. We would like to bring to your attention that Crawley Down Health Centre does not accept any responsibility if such an event should occur. (*If left unticked the practice may send a message, if deemed clinically appropriate or necessary*

CONSENT: I give consent for the Practice to leave messages by the following methods:

☐ Mobile Phone ☐ Home Phone ☐ Work Phone

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:

Relationship to you:

CONSENT: I give consent to RECEIVING the following information

☐ SMS (text appointment confirmation and reminders)

☐ E-mails – please ensure you have provided us with this information

Pharmacy Nomination

Please could you inform us of the pharmacy you wish to nominate for your prescriptions to go to.

Name of Pharmacy …… Location ……..

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

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.
The record will contain information about any medicines you are taking, allergies you may suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.
Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you were to have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health. Summary Care Records can help the staff involved in your care to make better and safer decisions about how to treat you.

Summary Care Record with Additional Information

You can now also choose to have additional information included in your summary care record, which can enhance the care you receive. This information includes:

- Your illnesses and health problems
- Operations and vaccinations you have has in the past
- How you would like to be treated – such as where you would prefer to received care
- What support you might need
- Who should be contacted for more information about you

As a patient you have a choice:

☐ **Yes I would like a Summary Care Record**

You do not need to do anything and a Summary Care Record will be created for you. Patients are advised that in doing so they give consent under the General Data Protection Regulation 2018 to their personal data being shared on a national system accessible from healthcare settings.

☐ **Yes I would like a Summary Care Record with Additional Information**

You do not need to do anything and a Summary Care Record with additional information will be created for you. Patients are advised that in doing so they give consent under the General Data Protection Regulation 2018 to their personal data being shared on a national system accessible from healthcare settings.

☐ **No I do not want a Summary Care Record**

Please ask the Receptionist for the opt-out form, complete it and hand it to a member of the GP practice team.
For more information, telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020

You can choose not to have a Summary Care Record and have the right to change your mind at any time by informing your GP practice.

If you are a parent or guardian with children under 16 you will have to make this choice for them unless you feel that they are old enough to understand and make their own choice.

SIGNED …….. **DATE ……..**