HOLLOW WAY MEDICAL CENTRE – NEW PATIENT HEALTH QUESTIONAIRE

Welcome to Hollow Way Medical Centre. Please take a few minutes to complete this form. This will help us find out more about you and your health needs, and enable us plan our services for the future. This information is confidential and will not affect your registration with us. We would be grateful if you can also complete the alcohol questionnaire at the bottom of the second page.

We may contact you via your email address or mobile phone number, including text reminders and other messages. If you DO NOT wish to be contacted in this way please tick this box ☐

PERSONAL INFORMATION **DATE COMPLETED:**

Surname First Name

Date of birth Sex Male/Female

Address

E-mail address:

Post code Telephone number: Home:
Mobile:

Status (*please circle)* Single Divorced Widowed Married Living with partner

Next of kin Next of kin contact details

Your relationship to Next of kin

Do you have any disability or any special information or communication requirements? **YES/NO**
If yes please give details

Would you be interested in joining our Patient Participation Group? **YES/NO** If yes, we will contact you.

Ethnic origin (*please circle)-drawn from 2001 Census*

White
White British Irish Polish Other white background

Mixed
White & Black Caribbean White & Black African White and Asian Other mixed background

Black or Black British
Black Caribbean Black African Other Black background

Asian or Asian British
Indian Pakistani Bangladeshi Other Asian background

Other ethnic groups
Chinese Other ethnic group (please specify)…….

First language *(please circle)* English Other *(please name)……...*

YOUR HOUSEHOLD

Are there any others in your household already registered with this practice? **YES/NO**

Are you the main carer for someone who is elderly, physically or mentally disabled? **YES/NO**
If **YES** please give details

Do you have a carer? **YES/NO**
If **YES** please give their name and contact number

Do you have a care agency supporting you at home? **YES/NO**
If **YES** please give their name and contact number

STUDENTS AND YOUNG PERSONS UNDER 25

Are you a full time student in Oxford? **YES/NO** If yes, when do you plan to finish? _____

Have you had an MMR vaccination? **YES/NO**

It would be very helpful if you could please bring in a copy of your immunisation records.

YOUR FAMILY'S HEALTH

Are there any serious medical conditions that run in **your** family?
Please circle and state age when diagnosed and relationship

Heart disease	**YES/NO**	Osteoporosis	**YES/NO**
Stroke	**YES/NO**	Cancer of the breast	**YES/NO**
Diabetes	**YES/NO**	Cancer of the ovary	**YES/NO**
High Blood Pressure	**YES/NO**	Cancer of the colon	**YES/NO**
Asthma	**YES/NO**	Others	**YES/NO**

YOUR CURRENT HEALTH

Are you on any medication? **YES/NO** If yes please give details

For women, have you had a hysterectomy? **YES/NO**

Are you allergic to or have you ever had any serious reactions to any drugs? **YES/NO**
If yes please give details

Have you ever smoked? **YES/NO**

Do you currently smoke? **YES/NO** If yes, how many do you smoke a day? _____

Would you like advice on quitting? **YES/NO**
If yes please make an appointment with one of the practice nurses.

What is your weight? _____(kgs) What is your height? _____ (cms)

ALCOHOL QUESTIONAIRE FOR PATIENTS OVER 16

1 drink = ½ pint of beer or lager, 1 standard glass of wine or 1 single measure of spirits

Please circle the answer which best applies to you

1. How often did you have a drink containing alcohol in the last year?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

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

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

3. How often did you have six or more drinks on one occasion in the last year?

Never Less than monthly Monthly Weekly Daily or almost daily

4. How much alcohol do you drink per week? (Please specify number of drinks) _____