Stopsley Village Practice

Patient Questionnaire: Adult

January 2018

Personal Details

Title: Mr / Mrs / Miss / Ms / Other

Surname:

Forenames:

Date of Birth:

Address:

Postcode:

Height: Weight: (If known)

Occupation:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Cohabiting

Contact Details

Home Telephone:

Work Telephone:

Mobile Telephone:

(Are you happy to receive appointment reminders by Text?)

☐ **YES** ☐ **NO**

Email Address:

Next of Kin Details

Name:

Address:

Patient Carer Details

Name:

Relationship:

Address:

Telephone Number:

PLEASE NOTE: **We are required to collect the following data by the Department of Health**

Ethnic Origin (please tick one)

- ☐ Asian or Asian British – Bangladeshi
- ☐ Asian or Asian British – Indian
- ☐ Asian or Asian British – Other Background
- ☐ Asian or Asian British – Pakistani
- ☐ African
- ☐ Caribbean
- ☐ Other Black
- ☐ Mixed Race – Other Background
- ☐ Mixed Race – White and Asian
- ☐ Mixed Race – White and Black African
- ☐ Mixed Race – White and Black Caribbean
- ☐ Other – Any Other
- ☐ Other – Chinese
- ☐ White – British
- ☐ White – Irish
- ☐ White – Other Background

First Language

We need to know your First Language – Please tell us which language is mainly spoken in your home:

Do You Smoke?

☐ Current Smoker → How many a day?

☐ Former Smoker → When did you quit?

☐ Never Smoked →

We can support you in giving up Smoking – Please make an appointment with the Smoking Cessation Advisor

Are you a Carer?
Do you look after someone who is ill, frail, disabled or mentally ill? **Yes / No**

Date:

Specimen Signature:

(This will only be used to confirm identity or consent)

Please Turn Over

Office Use Only	Identification Checked? ☐	Health-Check Date:	Details Checked By: Date:

Patient Medical Details

Personal Medical History

Year	Details

Is there a close family history (e.g. parents, brothers & sisters) of: (Please Tick ✓)

	Relation-ship	Age Under 60	Age Over 60
Heart Disease?			
Stroke?			
Diabetes?			

		Where of?
	Cancer?	
	Asthma?	
	High Blood Pressure?	

Current Medications

Medicine	Dosage
Please note that you MUST be seen by a Doctor prior to receiving any medication	

Known Allergies

Alcohol

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4 + times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10 +	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If Total Score is 5 or more, please make an appointment to see the Nurse				**Total Score**		

HIV

Luton has a higher than average rate of HIV infection. If you would like a blood test to check your status, please tick this box ☐