PATIENT QUESTIONNAIRE

WELCOME TO WOODLANDS HEALTH CENTRE. We hope our practice leaflet provides you with the information you require regarding the work of our Health Care Team. If you have any additional enquiries or problems, please contact our reception staff.

Thank you for filling out this questionnaire. It is used to assist the practice until your medical records have arrived as well as to assist with future planning and possible additional funding allocation, which will reflect the patients needs at the practice.

When you register please bring either your passport or driving licence AND a utility bill with your home address.

INVITATION FOR NEW PATIENT CHECK: If you have ongoing medical/health problems we would like you to make an introductory appointment with your doctor for a new patient check as your medical records take a while to come through; **book this within one month** of registering (please bring a urine sample with you and hand it to the receptionist).

Please answer the questions below and hand the completed form to the receptionist.

DATE OF REGISTRATION WITH PRACTICE ..... DATE QUESTIONNAIRE COMPLETED.....

TITLE: SURNAME: FORENAME:

DATE OF BIRTH: MARITAL STATUS: OCCUPATION:

PLACE OF BIRTH: PREFERRED LANGUAGE:

ADDRESS:

HOME TEL NO: WORK TEL NO: MOBILE TEL NO:

EMAIL ADDRESS:

NEXT OF KIN: RELATIONSHIP TO YOU:

ADDRESS: TEL NO:

OTHERS LIVING AT YOUR ADDRESS:

DO YOU HAVE A CARER? YES ☐NO ☐ ARE YOU A CARER? YES ☐NO ☐

If you have a carer and they are a patient at Woodlands Health Centre please give their name and address:

PLEASE LIST CURRENT MEDICATION- ALTERNATIVELY, PLEASE ATTACH YOUR REPEAT PRESCRIPTION SLIPS OR THE BOXES:

PLEASE LIST SIGNIFICANT ILLNESSES (PAST OR PRESENT) AND OPERATIONS:

PLEASE LIST ANY ALLERGIES:

ARE YOU A SMOKER? YES/ NO NUMBER OF CIGARETTES YOU SMOKE EACH DAY:

IF YOU ARE A NON-SMOKER: HAVE YOU EVER SMOKED REGULARLY? YES/ NEVER

IF YES, HOW MANY PER DAY? .....

PLEASE COMPLETE REVERSE OF FORM

If you are 16 or over please complete alcohol questionnaire.

	0	1	2	3	4
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	7-9	10+
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

RECORDING ETHNIC GROUP INFORMATION: This practice in line with other healthcare providers collects information about the ethnic group of patients. This information will help us plan to meet the health needs of the entire community and ensure that everyone has equal access to the healthcare we provide.
Please note that we are not asking about citizenship or nationality, but about the ethnic group to which you feel you belong.
The groups have been developed and agreed by the Office for National Statistics in conjunction with the Commission for Racial Equality.
Please tick the one of the boxes below that most accurately describes the ethnic group you belong to:

White
British □
Irish □
Any other white background □

Mixed
White & black Caribbean □
White & Black African □
White & Asian □
Any other mixed background □

Other ethnic group
Chinese □
Any other ethnic group □

Asian or Asian British
Indian □
Pakistani □
Bangladeshi □
Any other Asian background □

Black or Black British
Caribbean □
African □
Any other black background □

Other: ..... □

WHAT IS YOUR WEIGHT: WHAT IS YOUR HEIGHT:

WHEN DID YOU HAVE YOUR LAST TETANUS INJECTION:

WHAT OTHER VACCINATIONS HAVE YOU HAD? WHEN?

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WOMEN ONLY:
WHEN WAS YOUR LAST CERVICAL SMEAR?

WHEN WAS YOUR LAST MAMMOGRAM?

FAMILY HISTORY:
HAS ANYONE IN YOUR CLOSE FAMILY HAD HEART TROUBLE BEFORE THE AGE OF 60?

IF SO, WHO: MOTHER..... FATHER..... SISTER..... BROTHER.....

IS THERE ANYONE IN YOUR FAMILY WHO SUFFERS FROM: (please specify relationship)

BLOOD PRESSURE ..... ASTHMA ..... GLAUCOMA .....

STROKE ..... DIABETES ..... CANCER .....