WHITEHILL & FAIRFORD LEYS SURGERIES PATIENT QUESTIONNAIRE

Thank you for completing this questionnaire. It is used to help the practice to provide you with good medical care until your medical records have arrived.
To enable you to register we need official ID such as your passport/photo card driving licence AND a utility bill/bank statement etc with your home address dated within the last 6 months.

TITLE: SURNAME: FORENAME: DATE OF BIRTH:

MARITAL STATUS: OCCUPATION: NAME OF SCHOOL (16yrs & under):

OTHERS LIVING AT ADDRESS:

PREFERRED LANGUAGE: DO YOU NEED AN INTERPRETER:

HOME: WORK: MOBILE:

EMAIL ADDRESS:

I agree to being contacted by the surgery via mobile phone and email as above YES/NO

I agree to become a member of the Virtual Patient Participation Group? YES/NO
(*You will be sent newsletters, patient surveys and related information*)

NAME OF NEXT OF KIN: RELATIONSHIP TO YOU:

ADDRESS: TEL NO:

CARER INFO:
Do you look after someone? YES/NO Does someone look after you? YES/NO

SUMMARY CARE RECORD
Please indicate your choice:

☐ I choose to have a Summary Care Record so that details of my medications and allergies are accessible should I visit a clinician elsewhere in the UK

☐ I choose to opt out of having a Summary Care Record and understand that information regarding medication and allergies will not be accessible to other clinicians in the UK if and when I attend elsewhere for care

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ARE YOU A VETERAN / SERVED IN THE ARMED FORCES FOR 1 YEAR+? YES / NO

WHAT IS YOUR WEIGHT: WHAT IS YOUR HEIGHT: WAIST SIZE:

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. 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: …… □

******PLEASE COMPLETE REVERSE OF FORM******

Please circle :
ARE YOU A SMOKER / EX SMOKER / NON SMOKER

NUMBER OF CIGARETTES YOU SMOKE EACH DAY:

IF YOU ARE A SMOKER: WHICH OF THE FOLLOWING METHODS DO YOU USE TO SMOKE:

☐ CIGARETTES ☐ OWN ROLLED CIGARETTES ☐ CIGARS ☐ PIPES ☐ WATERPIPES ☐ ELECTRONIC CIGARETTES

IF YOU ARE A EX-SMOKER: NUMBER OF CIGARETTES SMOKED A DAY? ☐ DATE STOPPED:…….

EXERCISE:

☐ 0 TIMES A WEEK ☐ 1 TIME A WEEK ☐ 2 TIMES A WEEK ☐ 3+ TIMES A WEEK

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:

WOMEN ONLY:
DATE OF LAST CERVICAL SMEAR? DATE OF LAST MAMMOGRAM?

FAMILY HISTORY:
HAS ANYONE IN YOUR CLOSE FAMILY HAD HEART TROUBLE? *PLEASE STATE AGE OF ONSET:*

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 ……

FOR OFFICE USE ONLY:

TYPE OF PHOTO ID SEEN :…….. EXPIRY DATE: ……..

PROOF OF RESIDENCY WITHIN PRACTICE AREA PROVIDED:…….

DATE ON THIS EVIDENCE: …….

INFORMATION CHECKED BY ……. DATE:……

STAFF CONFIRMATION THAT FORMS HAVE BEEN CHECKED TO ENSURE FULLY COMPLETED :

STAFF NAME …….

REGISTRATION AND QUESTIONNAIRE DETAILS INPUT BY …… DATE ……