WATERBEACH SURGERY

ADULT HEALTH QUESTIONNAIRE (AGE 16+).

Please complete the following questionnaire for us to update your records. If you are unable, or do not wish to answer any of the questions please leave them blank. This information is confidential and will be seen only by yourself and the practice staff.

Title…… Full name …… Date of Birth ……..

Address……...

Telephone (Home)…… Mobile ……..……

Email ……..

We may use any mobile phone number and email address given to send you a communication about your care e.g. messages and reminders about appointments, test results, or to invite you for an appointment. We will only use these contact details with regard to your care.

You do have the right to provide your mobile phone number for calls only.
Are you happy for us to contact you by text? YES / NO

Accessible Communication Needs

With regards to how we give you information, or communicate with you:
Do you have any support needs relating to any disability, impairment or sensory loss? YES / NO

If Yes, please tell us what your needs are ……...

Please let us know how we can best communicate with you and give you information e.g. do you use BSL, large print, Braille

or other communication support? ……

Which pharmacy would you like your electronic prescriptions to go to?

……

Summary Care Record

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone, which can at times, slow down treatment. Summary Care Records have been introduced to improve the safety and quality of your care. Because this is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when we are closed.

Your Summary Care Record will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. It will also include your name, address, date of birth and your unique NHS Number to help identify you correctly.

As a patient you have a choice. Please select one of the following.

□ **Yes I would like a summary care record** - you do not need to do anything else

□ **No I do not want a summary care record** – Please complete an opt-out form. This is available at Reception if you don't already have one.

Your Health Record and sharing of information – please read and select your options below.

Your health record includes medical history, medication and any allergies you may have. You can now choose whether to share these full medical details. We use a secure electronic health records system called SystmOne. With your permission, this system can allow clinicians to share the record held here with other healthcare services that you may need to use e.g. out of hours services, children's services and community services. These other services will ask your permission to view the record. You have two choices, which allow you to control how your record is shared and you can change these choices at any time by letting the relevant practice or service know.

SHARING OUT – This controls whether record information recorded at this practice can be shared with other healthcare service e.g. the out of hours service. Please select one of the options below.

I would like my health record at this practice or service to be shared with other healthcare services providing care for me YES □ NO □

SHARING IN – This determines whether or not this practice can view information in your record entered by other services. Please select one of the options below.

I would like this practice to be able to view information in my health record that has been recorded by other healthcare service. YES □ NO □

PAST MEDICAL HISTORY **-** Please circle any of the following illnesses that apply to you.

Asthma COPD Heart Disease Stroke Diabetes Epilepsy

MEDICATION: Please list any regular medication e.g. tablets, liquids, creams, oral contraceptive pill and state the dosage and frequency of use.

…….

…….

ALLERGIES: please list…….

NEXT OF KIN

Name……. Relationship……

Address……..

Postcode…… Telephone……...

CARER

Are you currently a carer for an elderly/chronically ill family member? **YES/NO**

If so, who do you care for?.....

If you are elderly/chronically ill, do you have a family member who is your carer? **YES/NO**

If so, who is your carer?.....

MAIN LANGUAGE

Which language is your main spoken language? ……..

ETHNICITY

Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate care, as well as the clinical benefits as some diseases are more common in some ethnic groups.

Please select one of the following

What is your ethnic group?

Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background.

a. White

British □

Irish □

Scottish □

Any other white background, *please write in*…….....

b. Mixed

White and Black Caribbean □

White and Black African □

White and Black Asian □

Any other mixed background*, please write in*…….....

c. Asian or Asian British

Asian British □

Indian □

Pakistani □

Bangladeshi □

Any other Asian background*, please write in*……

d. Black or Black British

Black British □

Caribbean □

African □

Any other Black background, *please write in*……

e. Chinese and other ethnic group

Chinese □

Any other, *please write in*……..

ALCOHOL STATUS

Do you currently drink alcohol? YES/NO

If yes, please circle correct choices below

Questions	Scoring scheme					Enter score below
	0	1	2	3	4	
1. How often do you have 8 drinks (for a man) or 6 drinks (for a woman) on one occasion.	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Only consider the following questions if the above question scored 2 or more.

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3. How often during the last year have you failed to do what is normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. In the last year has a relative or friend, or a doctor or health worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Total >= 3 is positive – patient should be offered full screening test

SMOKING STATUS

Section 1

Do you currently smoke? YES/NO …….

If NO, go to section 2 **If YES, please go to section 3**

Section 2 (Please fill this section in if you do NOT currently smoke.)

Have you ever smoked? YES/NO ……..

If YES, at what age did you start smoking? ……

When did you stop smoking? .....

Section 3 (Please fill this section in if you are a current smoker)

Would you like to give up smoking? YES/NO?

Smoking Advice

As you may know, there are many health risks involved in smoking, e.g. smoking just one cigarette a day trebles your risk of lung cancer and raises the risk of chronic lung disease, as well as cancer of the mouth, throat, bladder, pancreas and many more.

There are also many health benefits to those who give up, for your health, your family and also your wallet!

Here at the surgery we can help you to quit, offering advice plus NHS prescriptions for nicotine patches, gum etc.
If you want to quit, even if you have tried many times before, please call the surgery to book an appointment with our Health Care Assistant.

If you are aged between 40 and 74, please book a 20-minute Health Check with the Health Care Assistant sometime within the next 3 months. Please bring a urine sample with you to this appointment. Thank you.

G/forms etc for printing/16+ patient history sheet