Hollyns
HEALTH & WELLBEING

Patient Questionnaire

Today's date……

Marital Status (please circle): Mr / Mrs / Miss / Ms / Dr Other: (please specify) .....

Full name: …… Date of birth: …….....

Address: ..…….....

Tel No: (home) ……..... (work) ……. (mobile) ....…….....

Email address: …….....

Main spoken language……..

Family Members for children under 18 years

- **Parent(s) or Guardian(s)**

  Name…… Registered at Hollyns Health & Wellbeing YES/NO

  Relationship……..…….. DOB…….. Contact Number……..……

  Name…… Registered at Hollyns Health & Wellbeing YES/NO

  Relationship……..…….. DOB…….. Contact Number……..……

- **Sibling(s)**

  Name…… Date of Birth……

  Name…… Date of Birth……

  Name…… Date of Birth……

  Name…… Date of Birth……

  Name…… Date of Birth……

  Name…… Date of Birth……

  Name…… Date of Birth……

Past Medical History:

Do you suffer from/have had: (please circle which applies)

Asthma/COPD or any respiratory disease…… Yes / No

A heart condition……..….. Yes / No

Stroke……..……. Yes / No

Diabetes…… Yes / No

High blood pressure…….... Yes / No

At risk of diabetes…… Yes / No

If you have repeat medication(s), providing you meet the required criteria, would you like to be considered for Repeat Dispensing? This would mean your medications would be issued automatically.

Yes ☐ No ☐

Please give details of any serious operations / illnesses that you have had:
……
……

Family History:

Do you have a family history i.e. brother, sister, mother or father with any of the following conditions:
(Please circle which applies and state which family member e.g. mother)

FH: Heart disease (such as a heart attack or angina) at less than 60 years **Yes / No**….....

FH: Heart disease (such as a heart attack or angina) at more than 60 years **Yes / No**.....

FH: Cerebrovascular event (such as a stroke or TIA) **Yes / No**……..……..

FH: Asthma **Yes / No**…….....

FH: Diabetes **Yes / No**…….....

Lifestyle:

Smoking status (12 years and over only)

Are you a current smoker?

- ☐ Yes
- ☐ Never smoked
- ☐ Stopped smoking (within last 12 months)
  Pease state when stopped smoking ……
- ☐ Ex – smoker (quit smoking for 12 months or longer)
  Pease state when stopped smoking ……

If a smoker, please circle what you smoke: Cigarettes / cigar / pipe / rolls own cigarettes / chews tobacco

How many do you smoke a day?

- ☐ Trivial smoker (less than 1 cigarette a day)
- ☐ Light smoker (1-9 cigarettes a day)
- ☐ Moderate smoker (10-19 cigarettes a day)
- ☐ Heavy smoker (20-39 cigarettes a day)
- ☐ Very heavy smoker (40 or more cigarettes a day)

Have you ever or do you currently use an electronic cigarette?

- ☐ I use a nicotine electronic cigarette
- ☐ I use an electronic cigarette without nicotine
- ☐ I have previously used a nicotine electronic cigarette
- ☐ I have never used an electronic cigarette

Would you like help to quit smoking? If so, you can call *Living Well Stop Smoking Service* today on 01274 437700

Sharing your electronic medical information (6 years and over only)

Please note children aged 0-5 years are automatically shared.

Sharing Out - Do you consent to the sharing of data recorded here with any other organisations that may care for you?

☐ Yes - share data with other organisations ☐ No – do not share any data recorded here

Sharing In – Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you, where you have agreed to make the data shareable?

☐ Consent given ☐ Consent refused

Please note, if you refuse this option and you access another NHS service, they may not be able to access your medical record.

New Patient Screening (aged 5 years and over)

All new patients are invited to attend a 'New Patient Health Check'. Please tick one of the following:

Yes, I would like to arrange a NPHC ☐ No I do not wish to arrange a NPHC ☐

If you have answered Yes, please speak to a receptionist who will arrange an appointment for you.

Consent form for text messaging service

We have a system in place for informing you of your blood/sample and X ray results, including appointment reminders.

If you provide the practice with your mobile number, we assume you consent to receiving all results and any appropriate medical reminders from Hollyns Health & Wellbeing via a text message to your mobile phone.

☐ **Yes** - I accept that it is my responsibility to inform the surgery if I change my mobile telephone number

☐ **No** – To receive your results please ring the surgery after 10.30am Monday to Friday. Please note we no longer automatically send a letter informing of results.

If you do choose the text message service, it is your responsibility to inform us if you change your mobile phone number. The surgery cannot be held responsible for network failure.

Suggestions

If you have any suggestions/comments that you think will improve the service, you receive from the Practice please write below.

Suggestions/comments

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Thank you for taking the time to complete this questionnaire.