FORM 3
PATIENT QUESTIONNAIRE

This questionnaire is confidential and helps to give us background information about your health, which can help us to improve your health care. Please answer all questions and tick the appropriate box.

Name: **Date of Birth:**
Previous Surnames: **NHS No:**
Address: **Religion:**
Postcode:

Telephone No.: Home: **Work:** **Mobile:**
Preferred Telephone Number :
E-Mail Address: **Occupation:**

Height: **Marital Status:**
Weight:

First Language: **Interpreter required?: Yes/No**
Alt. Correspondence Format: **Braille / Large Print (Please circle if appropriate)**

Ethnicity: (please circle as appropriate)

White/British	W&B Caribbean	Indian/British	Caribbean
British/Mixed	W&B African	Pakistani/British	African
Irish	White & Asian	Bangladeshi/British Bangladeshi	Other Black
Other White	Other Mixed	Other Asian	Chinese

SMOKING STATUS?
Do you smoke? **Yes/No**
If 'No', have you ever smoked? **Yes/No** **Quit Date……**
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week? ……
Would you like advice on giving up smoking? **Yes/No**

ALCOHOL
How much alcohol do you drink in a typical week ? ……. Units per week
(Approx 1 unit = half a pint of beer = 1 measure of spirits= 1 small glass of wine = 1 glass of sherry)

How often do you have a drink containing alcohol?	Never/Monthly or less(1)/2-4 times a month(2)/2-3 times a week(3)/4+ times a week(4)
How many units of alcohol do you drink on a typical day when you are drinking?	1-2(0)/3-4(1)/5-6(2)/7-9(3)/10+(4)
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never(0) / Less than monthly(1) / monthly(2) / weekly(3) / daily or almost daily(4)

HOW OFTEN DO YOU TAKE EXERCISE?

Never	[ ]	Once a week	[ ]
Two or three times	[ ]	More	[ ]

Please describe the exercise you take:

DO YOU HAVE ANY ALLERGIES TO FOOD OR MEDICINE, please state?

HAVE YOU EVER SUFFERED FROM: [if yes, please state approx. date of diagnosis?

Epilepsy	[ ]	High Blood Pressure	[ ]
Diabetes	[ ]	Asthma	[ ]
Heart Disease	[ ]	Blindness	[ ]
Heart Attack	[ ]	Glaucoma	[ ]
Stroke	[ ]	Depression	[ ]
Cancer	[ ]	COPD	[ ]
Eczema / Hayfever	[ ]	Anxiety	[ ]
OCD	[ ]	Bipolar Disorder	[ ]
Other	[ ]		

Do you have any other mental health issues? If yes, please give details Yes/No
……

-HAVE YOU HAD ANY MAJOR ILLNESS OR OPERATIONS? [if yes, please give details]

ARE YOU RECEIVING OR HAVE YOU HAD ANY TREATMENT OR THERAPY? [if yes, please give details]

PLEASE LIST ANY MEDICATION BEING TAKEN, THE DOSAGE AND THE AMOUNT:

Prescribed by Doctor:

Purchased over the counter:

Family History:
Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual, their age at which they developed the illness and in the case of cancer, the type of cancer:

ARE YOU REGISTERED DISABLED? [If yes, please give details]:

DO YOU HAVE ANY COMMUNICATION / INFORMATION NEEDS: [If yes, please give details of what your needs are] :

FEMALES ONLY
Date of your last cervical smear if applicable . . . . . .
Where was the last smear taken (ie Hospital, Doctor's surgery). . . . . .
Have you ever had an abnormal smear? . . . . . .
If yes, when and the result? …….
Do you examine your breasts regularly or have you attended the Breast Screening Unit? Yes/No
Please give details of last screening test …….

What contraception do you use? (If applicable) …….

REFUSAL OF TREATMENT:
Have you ever refused treatment / screening of any kind and if so, what and when?

CARERS

Do you have a carer? [If yes, please give details] Yes / No

Are you a carer? [If yes, please give details] Yes / No

WILL

Do you hold a living will? [A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness **YES/NO**

FOR PATIENTS AGED 65 and Over or those with a chronic disease [e.g. asthma/ diabetes

Have you ever had a flu vaccination? [If yes, please give date] Yes/No …….
Have you had a pneumococcal vaccination? [If yes, please give date] Yes/No …….

IMMUNISATION HISTORY

Please give details and dates of any vaccinations you have received:

NEXT OF KIN

Please give name, address and telephone number and relationship of next of kin:

FIREARMS LICENCE

Do you currently hold a FIREARM/SHOTGUN LICENCE? **YES/NO**

BRITISH ARMED FORCES

Have you ever served in the British Armed Forces? **YES/NO**

CONTACTING YOU

I agree that I may be contacted from time to time, via email and/or SMS, with practice news, advice about my health and/or appointment reminders. Yes [ ]

The Summary Care Record (SCR) is a summary of a patient's allergies and current medication uploaded to Spine so that it can be accessed by any legitimate carer, regardless of the computer system they use.

The circumstances when this is beneficial include when a patient is seen at a hospital or Out of Hours unit or when a temporary resident is seen at a GP practice.

Would you like a summary care record **yes / no**

Consent to receive SMS Text Messages **yes / no**

Electronic Prescribing is now available at our surgery. Please nominate your preferred pharmacy :

……

Patient please sign …… Date: ……

THE INFORMATION PROVIDED SHOULD BE CORRECT AND IS USED BY THE PALL MALL SURGERY TO UPDATE YOUR MEDICAL HISTORY ON YOUR COMPUTER RECORDS AND HELP US TO ORGANISE THE CARE YOU WILL BE OFFERED BY THE CLINICAL TEAM.

Please give full name, date of birth, address of any other family members registered with us. Please add information below :