1)

GROOMBRIDGE & HARTFIELD MEDICAL GROUP
PATIENT QUESTIONNAIRE

We are organising your medical records so that we have as much relevant information as possible about your health. We are grateful for your co-operation in completing this questionnaire.

Surname: ____________________ Forename (s): __________________

Date of Birth: _________________ Age: _____________________

Occupation: ____

Address: ____

____

__________________________ Postcode: ____________________

Home Tel: ________________ Work: _______________________

Mobile: ____________________Email: _______________________

Marital Status: (please circle)
Married/Single/Divorced/Separated/Widowed/Civil Partnership
Do you live – Alone/Sharing/With Partner (please circle)

Please detail other adults/children living at the same dwelling:

Name **DOB** **Relationship to patient**

____
____
____
____

Continue on a separate sheet if necessary

Next of Kin: ______________________ Relationship: _____________
Address of next of kin: _____________________________________

Personal Medical History

Please list any major illnesses or operations you have had, particularly those which required hospital admission. Give approximate if you are unsure of exact dates. Please mention any chronic medical conditions such as asthma, diabetes or heart diseases (e.g.: high bloods pressure, heart attack, angina, and stroke)

YEAR	CONDITION

2)

FAMILY HISTORY

Please circle if your parents, brothers or sisters have had any of the following:-

CANCER OF THE BOWEL   DIABETES

CANCER OF THE BREAST   DEPRESSION

ASTHMA   GLAUCOMA

Relative   Age

Heart Attack: ______________________________

Stroke: ___________________________________

Blood Pressure: ___________________________

Are there any hereditary or important illnesses?

____

What is your method of contraception?

____

When did you last have a smear test? ____________

Have you ever had a mammogram? YES/NO

If so, when? __________

Pregnancies (full term/miscarriages/full term/caesarean/breast fed)

Year	Normal/Any Problems	Breast Fed

What is your height? ____

What is your weight? ____

When was your last tetanus vaccination? ____

What other vaccinations have you had in the past 5 years?

____

____

____

____

3) **REPEAT MEDICATION**

Please list all medication that you take on a regular basis.

Name of Drug	Strength	No. of Tablets	No. of times per Day

Do you have any drug allergies? YES/NO
If so, please list them.

____

List any over the counter medicines you take regularly.

____

GENERAL HEALTH

How often do you eat the following?

	Daily	2-3 times/week	Once a week	Occasionally	Never
Fruit & Vegetables					
Fibre Rich Food					
Fried Food					

How often do you exercise? (please circle)
Every day/2-3 times a week/Once a week/Occasionally/Never

What sort of exercise (please circle)
Walking/Cycling/Jogging/Swimming/Weights/Gym/Aerobics/Other

Have you ever been a smoker? ______

From (age) ______ until (age) _____

How many per day? _____

Do you wish to stop smoking? _______

Has your blood pressure been checked the last three years? _____

How many units of alcohol do you drink per week? _____
(1 unit = 1 small glass of wine, 1 single spirit, half pint of ordinary strength beer).

4) ACCESSIBLE INFORMATION

Please answer the following questions:-

a) Do you have any difficulty with communicating or accessing information? **YES/NO**

b) Please tell us about your needs, e.g., Do you have a Disability, Impairment or Sensory Loss? **YES/NO**

c) How can we best meet your needs?

OFFICE USE

Pass to HM if Accessible Information Page completed ☐

HM: Read Code Xa4Cq applied to patient record ☐

5) **RECORDING OF ETHNIC GROUP**

Information for Patients

This practice, along with other healthcare providers, collects information about the ethnic group of patients. This information can help us plan and meet the needs of the community to ensure that everyone has equal access to the healthcare we provide.

Please note we are not asking you about citizenship or nationality, but about the ethnic group to which you feel you belong.

All the information we receive will be used and treated with the strictest confidence. Any information used for service planning purposes will be anonymous with all names and other identifying information removed.

The classification is entirely voluntary.

What is your ethnic group?
Choose one option that best describes your ethnic group or background.

White
1. English/Welsh/Scottish/Northern Irish/British
2. Irish
3. Gypsy or Irish Traveller
4. Any other White background, please describe

Mixed/Multiple ethnic groups
5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Any other Mixed/Multiple ethnic background, please describe

Asian/Asian British
9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background, please describe

Black/African/Caribbean/Black British
14. African
15. Caribbean
16. Any other Black/African/Caribbean background, please describe

Other ethnic group
17. Arab
18. Any other ethnic group, please describe

OFFICE USE
Information added to Systm1 ☐
HCA Review of Questionnaire ☐