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**Healthcare Questionnaire Form**

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| **Patient: *please print only*** | | | | | | |
| Full name: | | | | | | |
| **Date of Birth:** | | | **Country of birth:** | | | |
| **Contact Numbers:** | | **Communication issues:** | | | | |
| **Home:**  **Mobile:** | | **Vision or hearing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Interpreter required Y N**  **Sign Language required Y N** | | | | |
| **Email address:** | |
|  | | | | | | |
| **Carer details:** | | | | **Next of Kin details:** | | |
| **Are you a Carer: Y N**  **Do you have a Carer: Y N**  **If so Contact Details:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient is in Care Y N**  **Nursing / Residential Home Y N**  **in Foster Care Y N**  **a child under age of 18 YN**  **Patient is housebound Y N**  **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **Relationship ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Contact details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Power of Attorney Y N**  **Info:** | | |
| |  | | --- | | **Authority for 3rd party collection:**  ***please tick below if required, you will need to support this with a signed letter of your approval with signatures of both parties before this can be actioned*** | | **I give authority for 3rd parties to collect PRESCRIPTIONS on my behalf □** | | **I give authority for 3rd parties to collect DOCUMENTS on my behalf □** |     New Patient Health check Questionnaire 2019 | | | | | | | |
| **Medical Conditions:**  *eg Asthma, Diabetic, COPD, heart disease etc* | | | | | | | |
| **Past or Present Medical Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Are you on any repeat medication: Yes No**  **Do you have any known allergies: Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    All Nursing / Care homes patients must provide a brief summary from their previous GP when registering. | | | | | | | |
| **Prescriptions** | | | | | | | |
| **EPS (electronic prescription service) for your convenience.**  **Choose a local pharmacy and we will send your regular prescription direct for you to collect**  **Nominated Pharmacy :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **Alcohol:**   * One unit is 10ml or 8g of pure alcohol. Because alcoholic drinks come in different strengths and sizes, units are a way to tell how strong your drink is.  men and women are advised not to drink more than 14 units a week on a regular basis | | | | | | | |
| **1 UNIT** | Single small shot of spirits \* (25ml, ABV 40%) | | | | **3 UNITS** | Large glass of red/white/rosé wine (250ml, ABV 12%) | |
| **2 UNITS** | Can of lager/beer/cider (440ml, ABV 5.5%) | | | | **Your weekly unit consumption:\_\_\_\_\_\_\_\_\_\_\_** | | |
|  | | | | | | | |
| **Smoking:** | | | | | | | |
| **Do you smoke? Yes No**  **If Yes how many a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If Yes would you like help to stop smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |

**I consent for my data to be used by the practice to manage my healthcare. I understand I can access the Practice Privacy Notices via the Woodcote Medical Website:** [www.woodcotemedical.nhs.uk](http://www.woodcotemedical.nhs.uk)

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Office Use:   1. 2 forms of ID - Photo ID and Utility Bill 2. Inform Patient it will be 48 hours before they are registered and to use the hubs in the mean time for their medical needs. 3. Check with patient that all forms are completed in FULL 4. Send pt an invite to a health check via Accurex 5. Start the template for pts NHS health check using all info provided on the health questionnaire   Receptionist sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reception Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |