PLEASE COMPLETE THIS FORM USING BLACK PEN AND BLOCK CAPITALS

Pt No. _____

Initials

Thank you for taking the time to complete this questionnaire. Please return the completed form to the surgery with form GMS1.

IMPORTANT: This information will be stored on a computer database held by the practice but will be shared with the wider NHS under an arrangement called the `Summary Care Record'. The NHS assumes your consent to upload this data unless you actively opt out in which case you must sign the `**Opt Out Form'**. We can then tag your file to prevent file sharing. You can change your decision about this at any time. Further information about this is available on our website www.hodfordroadsurgery.co.uk.

Surname First names

Address

Telephone: Home: Mobile: Email:

Date of birth Place of Birth Marital Status

Occupation Ethnic Group First Language_____
(see guide to ethnic groups on reverse of cover letter)

Next of Kin/Principal Carer
Name Address

Telephone **Are you a carer? YES/NO Does someone care for you? YES/NO**

PERSONAL MEDICAL HISTORY

Please list any serious illnesses or operations you have had in the past

1. 2.

3. 4.

Please list all medicines which you take regularly

1. 2.

3. 4.

Are you allergic to any medicines? (please circle) No/Yes

If yes, please give further details

When did you have any of the following vaccinations? **(please fill in date)**

	First	Second	Third	Booster
DTaP				
Polio				
Hib				
Meningitis C				
Mumps/Measles/Rubella				
BCG				
Pneumonia				
Influenza				
Typhoid				
Hepatitis A				
Hepatitis B				
Yellow Fever				
Rabies				
Others				

Where were these vaccinations given? **(please circle)** GP Other

Is there a family history of Heart disease/Stroke/Diabetes/Cancer/Glaucoma or any other inherited conditions?
Please give details:

Condition	**Relative**	**Age at onset**

LIFESTYLE

Private Health Cover? YES/NO

(Please circle your chosen reply)

What has been your smoking habit in the last 5 years? Smoker Non Smoker Ex Smoker

Smoker of: Cigarettes Cigars Pipe

1/day 1-9/day 10-19/day 20-39/day 40+/day _____ Ounces?

Are you aware of the risks of smoking? Yes No

Have you considered stopping? Yes No

Smoking is hazardous to your health and those around you - especially pregnant women and children.

Alcohol: please answer the following questionnaire

The Fast Alcohol Screening Test (FAST)

Questions	*Scoring Scheme*					*Enter score below:*
	Score 0	1	2	3	4	
1.How often do you have 8 (for a man) 6 (for a woman) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only consider questions 2, 3 and 4 if the response to question 1 is less than monthly or monthly.						
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 a health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
					Total:	

If you scored 3 or more on the FAST test please download the full AUDIT – C alcohol screening test from our website and enclose this with your questionnaire.

Which description most closely matches your typical level of exercise? (please circle answer)

None physically impossible avoid any exercise enjoy light exercise enjoy moderate exercise

competitive athlete exercise unknown attend exercise classes

Regular exercise is important for maintaining and improving fitness.

12 sessions of 30 minutes over 4 weeks is advised for maintaining fitness.

If you would like advice or information about quitting smoking / sensible drinking / exercise or diet, please take a leaflet from the waiting room or make an appointment with the Practice Nurse.

THIS SECTION TO BE COMPLETED BY WOMEN ONLY

When did you last have a cervical smear test? _____Date

What was the result? _____

Where was it done? (please circle) GP Private (please say where done)

Routine smear tests are done at 3 yearly intervals from age 25 -49 and 5 yearly intervals age 50-65
If you are due a smear test please make an appointment with the Practice Nurse.

What contraceptive method (if any) do you use? _____

The practice nurse is trained in family planning. If you would like advice, please make an appointment to see her

If you are aged between 50-65 the NHS will invite you to have a mammogram every 3 years.
This is a simple screening test to detect early breast cancer

Is there any other information about your health or personal circumstances which you think we should know?

How did you hear about the practice? (please circle)

Personal recommendation Chemist Another doctor NHS Internet Other

Signature Date

The Practice manages the confidentiality of your medical records in accordance with the Data Protection Act 1998. Please note that medical records are subject to inspection by the Primary Care Trust or its equivalent, for the purpose of financial audit, record validation and research. Should you wish your records to be excluded from such inspection or use, please speak with the Reception staff.

Patient Representation Group: Would you like to help us improve our services? If so please join our Patient Representation Group by registering your interest through our website. We will email you from time to time with questionnaires about the surgery and would welcome your feedback. Go to the Patient Reference Group page on our website to register.

For Practice Use Only

Passport copy ☐ Proof of address ☐ Registration Details ☐ SCR (93C3) ☐