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…………………………………………………….

Next of kin: …………………………………….. Contact details: …………………………

Relationship: ………………………………… Is the individual registered at Hollyns: **YES / NO**

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…………………

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

Do you have any Drug Allergies: Yes / No (if yes, please state what you are allergic to)

……………………………………………………………………………………………….

If you have answered yes to any of the above, please book an appointment with the practice nurse for a review if you have not had one in the past 12 months.

Please list any medication that you are currently taking:
………………………………………………………………………………………………
………………………………………………………………………………………………

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 (please circle appropriate answer)

Are you a current smoker? Yes / No

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

If so, how many do you smoke daily ……………………………………………...

Are you an ex-smoker? Yes / No

If so, when did you stop? Date…………………………………………

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 (please state when last used) ……………………………
- ☐ I have never used an electronic cigarette

Are you are interested in attending our smoking cessation clinic: YES / NO

Patient Involvement (18 years and over only)

This practice is committed to improving the services we provide to our patients.

To do this it is vital that we hear from people about their experiences, views and ideas for making our services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give you your views and keep you up to date with developments within the Practice.

If you are interested in getting involved, please tick the box below and we will provide you with a copy of the Patient Group application form.

Yes, I am interested in becoming involved with the Patient Group ☐

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

Please note children aged 0-5 years old 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

Dear Patient

We have a system in place for informing you of your blood/sample and eventually your 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.

I accept that it is my responsibility to inform the surgery if I change my mobile telephone number.

My mobile number is: ………………………………………………

Signed: ……………………………………………………………

Print name: …………………………………………………………

Date of birth (for identification purposes): ………………………

Date: ………………………………………………………….........

Alternatively, to receive your results please ring the surgery between 1pm and 6pm, Monday to Friday and speak to the receptionist who will be able to book you into telephone results with a clinician.
Please note that we no longer automatically send a letter informing you of your 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

………………………………………………………………………………………………………
………………………………………………………………………………………………………
………………………………………………………………………………………………………

Thank you for taking the time to complete this questionnaire.