LADYWELL MEDICAL CENTRE (EAST)

**PATIENT QUESTIONNAIRE – ADULT**

## How we use your information:

## The information you have provided will be used by the GP Practice to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.

You will be issued with a Privacy Information Leaflet when you register. You can also find our full Privacy Notice on our website [www.ladywelleast.co.uk](http://www.ladywelleast.co.uk) or ask for a copy from Reception. Please contact the Practice Data Protection Officer if you have any queries.

If you would like a new patient health check please advise reception staff who will book you an appointment.

## Registration

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| Have you been registered at this Practice before: Yes / No If yes, approximately when? |

## Personal Details

|  |  |
| --- | --- |
| Full Name: | Date of Birth: / / |
| Address (inc postcode): | Tel Nos:Home:Work:Mobile: |
| Do you consent to receiving texts from the Practice in relation to appointments and your health to the mobile telephone number above: Yes / No (we can only text to UK mobile numbers)  |
| Marital Status: Single/Married/Separated/Divorced/Widow/Partner | Male / Female:  |
| Emergency contact (name and telephone number): |
| Are any family members living in the same house AND registered at this Practice (name and date of birth): |
| Do you need an interpreter? Y / N   | If yes, which language? |
| Preferred local pharmacy? (we will automatically send all prescriptions for you to this pharmacy unless you instruct us otherwise)  |  |

# Medications

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| Please list regular medications taken, including over the counter remedies |
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

# Your Health – Past and Present

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| --- | --- |
| Do you suffer from? (Please tick) | High blood pressure |
| Asthma or other chest complaint | Angina or other heart condition |
| Diabetes | Other (please state) |
| Have you had any serious illness or operations? |
| What: | When: |
| What: | When: |
| Do you have a visual or hearing impairment Y / N | If yes, please state: |
| Do you have any allergies? Y / N If yes, please provide as much detail as possible: |

**Blood transfusion / organ transplant information:**

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| Did you have a blood transfusion prior to 1996? Y / N |
| Have you received any blood products prior to 1986? Y / N |
| Did you have an organ transplant prior to 1992? Y / N |

**Healthy Living:**

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| Smoking Status: (please circle) Current Ex-Smoker and date stopped: Never  |
| Do you eat healthily? Y / N | Do you exercise regularly? Y / N If yes, what? |
| Do you drink alcohol: Y / NIf yes, how many units per week? | Height: | Weight: |

# Your family

|  |
| --- |
| Have any close family members (parents, children, siblings) had any of the following? Please tick and state which family member |
| Angina: | Stroke: | Mental Illness: |
| Heart Attack: | Epilepsy: | Glaucoma: |
| Cancer: | High B.P.: | Asthma: |
| Diabetes: | Any other serious illness: |
| Are you a carer? Y / N If yes, is the patient registered at Ladywell Medical Centre East? Y / N |
| What is the cared for person’s name: | Date of birth: |