LAKESIDE HEALTHCARE
at Oundle

ADULT QUESTIONNAIRE

SURNAME: ……………………………..**FORENAME (S):** ……………………………………………….**D.O.B:** …………………………….

ADDRESS: …….**POSTCODE:** ………….……

HOME TEL: ……………………………….....**EMAIL ADDRESS:** ………………………………………………………………………………………

MOBILE TEL: ……………………………. We currently use SMS as a means of communicating with our patients. Please indicate your preferences below. If this is left blank we will assume you do NOT want SMS reminders.

I consent to receive SMS messages from you ☐
I do **NOT** consent to receive SMS messages from you at all ☐

Signed: …………………………………………………. Date…………………………..

PLEASE STATE ANY CURRENT MEDICAL CONDITIONS or DISABILITIES:

FAMILY HISTORY - PLEASE ✓ WHICHEVER APPLIES: (Please state family member under each section)

Diabetes ☐ Stroke ☐ Asthma ☐ COPD ☐ Epilepsy ☐

High blood pressure ☐ Depression ☐ Cancer ☐ ____________(please state cancer site)

Heart Disease aged 60 or under ☐ Heart Disease Aged 60 or over ☐

DO YOU HAVE ANY ALLERGIES? N0 ☐ Yes ☐ Please state:

CURRENT HEIGHT: ……………………………………….. **CURRENT WEIGHT:** ……………………………………………………….
If you are unsure of these, please use our self-measure machine in the waiting room. This will also calculate your blood pressure and pulse rate.

SMOKING - PLEASE ✓ WHICHEVER APPLIES:

Never smoked ☐ Current Smoker ☐ How many daily ______ Electronic Cigarette user ☐

Ex-Smoker ☐ Date Ceased: Occasional Smoker ☐ Prefer not to answer ☐

Do you wish to receive advice to help you to stop smoking? YES ☐ NO ☐

EXERCISE - PLEASE ✓ WHICHEVER APPLIES:

Light *(Once a week)* ☐ Moderate *(Twice a week)* ☐ Heavy *(3+ times a week)* ☐

Impossible ☐ Avoid ☐

TO BE COMPLETED BY FEMALES ONLY PLEASE

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Contraception type (if applicable): Implanon ☐ Coil ☐ Oral ☐ Depo ☐

Date due for removal/renewal/repeat prescription:

Date of last cervical smear: Result:

Have you had a hysterectomy? No ☐ Yes ☐ Date:

IF YOU ARE ON REPEAT MEDICATION, PLEASE PROVIDE US WITH A COPY OF YOUR REPEAT PRESCRIPTION LIST

IF YOU ARE A CARER, OR HAVE A CARER PLEASE FILL IN A SEPARATE CARER'S FORM

To be completed by ALL patients aged 16-35 years:

Have you ever spent 6 months or more overseas? NO ☐
If YES, please state which Countries and answer the remaining questions:

Have you entered the UK within the last 5 years? YES ☐ NO ☐

Do you have a past medical history of TB? YES ☐ NO ☐

Have you ever been screened for TB? YES ☐ NO ☐

Ethnicity: (Please note that you do not have to complete this section)

White British ☐ British or mixed British ☐ Other White background ☐

Asian Indian ☐ Asian Pakistani ☐ Asian Bangladeshi ☐
Black Caribbean ☐ Black African ☐ Chinese ☐
Mixed White & Asian ☐ Mixed White & Black Caribbean ☐ Mixed White & Black African ☐

Other (Please state):________________________________ Prefer not to answer ☐

First language: **Do you require an Interpreter?**

Thank you for taking the time to complete this questionnaire

For Office Use Only *Patient Verification*

Documentation Seen: -

Seen by: ______________________________*Date:* __________________

Added to SystmOne By: ____________________________*Date:* __________________

New patient alcohol survey

We would like to offer you these alcohol screening questions to think about your use of alcohol:

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1 pint of standard beer =	**2 units**	**1 bottle of wine =**	**9 ~ 10 units**
1 glass of wine (175ml) =	**2 units**	**1 glass of wine (125ml) =**	**1.5 units**

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health care worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
				Total Score:		

If you have scored 8 or above you are at increased risk from your drinking. A Nurse will be in touch to discuss
Current guidance on healthy drinking is:

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Men	2 ~ 4 units/day	= 21units/week
Women	2 ~ 3 units/day	= 15 units/week

Patient information 'It's your choice' Online Services Records Access

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

Being able to see your record online might help you to manage your medical conditions. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

The information that you can see online may be misleading if you rely on it alone to complete insurance, employment or legal reports or forms.

Be careful that nobody can see your records on screen when you are using Patient Online and be especially careful if you use a public

The practice has the right to remove online access to services. This is rarely necessary but may be the best option if you do not use them responsibly or if there is evidence that access may be harmful to you. This may occur if someone else is forcing you to give them access to your record or if the record may contain something that may be upsetting or harmful to you. The practice

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Patient Details:

First name:	Surname:
Address:	Date of birth:
Telephone number:	Mobile number:
Email address:	

I consent to be contacted by SMS message: YES ☐ NO ☐

I wish to have access to the following online services (please tick all that apply):

1	Booking Appointments	☐
2	Requesting Repeat Prescriptions	☐
3	Accessing my Summary Record View	☐
4	Completing Questionnaires	☐
5	Accessing my Detailed (Coded) Record Set	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1	I have read and understood the information leaflet provided by the practice	☐
2	I will be responsible for the security of the information that I see or download	☐
3	If I choose to share my information with anyone else, this is at my own risk	☐
4	I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5	If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6	I understand that I may view data in my online record that the Doctor has not yet spoken to me about	☐

Patients Signature: ___________________________________

Your Username and Password will be posted to you at your home address within 5 working days

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For practice use only

<table>
<tr><td>Identity verified by (initials):

Date:</td><td>Method:
Vouching ☐
Photo ID ☐
Proof of residence ☐</td></tr>
<tr><td>Date account created:</td><td>Authorising Staff Member:</td></tr>
<tr><td colspan="2">Notes/Explanation:</td></tr>
</table>