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……………………………

***Preferred Method of Contact:*** SMS ☐ Letter ☐

**NEXT OF KIN**
**NAME:** **RELATIONSHIP:**
**ADDRESS:**
**TEL:**

**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?** No ☐ 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 ☐

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**EXERCISE – PLEASE ✓ WHICHEVER APPLIES:**

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

Impossible ☐ Avoid ☐

**NOMINATED PHARMACY ✓YOUR PREFERENCE:**

☐ I live more than one mile from the nearest chemist and wish to collect my medication from the surgery (Only available to those in the surrounding villages, not including Ashton)

☐ Boots (Oundle) ☐ Oundle Pharmacy (Post Office) ☐ Other (please state):

**TO BE COMPLETED BY FEMALES ONLY PLEASE**

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 Total 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**

**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?** No ☐ Yes ☐

**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:* ________________