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 ☐

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 ☐
If you tick YES to receiving advice to help you stop smoking, we will refer you to one of our smoking cessation nurses.

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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

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?**

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:* _____

Last update: 11.09.19 KY