Stainland Road Medical Centre

70 Stainland Road, Greetland, Halifax, HX4 8BD. Tel: 01422 374109
www.stainlandroadmedicalcentre.co.uk

Thank you for completing this patient questionnaire. The information you provide will help us to offer you the best possible care. Also depending on your information we may invite you to see one of our healthcare professionals to discuss your need further. Any information provided will only be used in connection with your health record and not for any other purpose. By providing your mobile number / email you are consenting to it being used for these purposes. Any patients who DO NOT wish to be sent text messages MUST contact the surgery to 'opt out' of this service.

Surname..... Forenames..... Title ….....

Date of birth..... Country of Birth ....…….....

Address ……..

..... .Postcode ……..

Telephone numbers: Home.....Mobile.....

Work …….. E-Mail……

Marital Status……..

Military Veteran Have you ever been a member of the armed forces for more than one day Y/N.....

Ethnicity (please circle the most relevant)

White British

White Irish

Any other white background

Any other mixed background

White/Black Caribbean

Black British

Other ethnic group ……

Indian

Pakistani

Bangladeshi

Any other Asian background

Other Black background

Chinese

Main Spoken Language

Main Spoken Language English ☐

Main Spoken Language Other
Please state

…….

EMERGENCY CONTACT DETAILS

NAME & RELATIONSHIP …….....

TELEPHONE NUMBER……

ID Type:

Number:

SYS _____ mmHg
MAP _____ mmHg
DIA _____ mmHg
PUL _____ b p m

P.T.O.

Revised August 2019

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eDSM (Enhanced data Sharing Model)

eDSM is to allow **FULL electronic medical record** to be shared (by giving consent your data will be available in a central pool so that other medical services can access that data **if they also get your permission.** We need consent both IN and FROM)

Do you consent to the information that is recorded about you here being made available to other NHS care services that care for you and also use SystmOne?

YES ☐ **NO** ☐

Do you consent to allow Stainland Road Medical Centre to view information about you that has been recorded at other services where you also receive care? (You must have separately consented for information to be 'shared out' of those services)

YES ☐ **NO** ☐

Risk Profiling Enhanced Service (XaaVL)

Using information from your health records, a secure NHS computer system will look at any recent treatments you have had in hospital or at this surgery, and any existing health conditions that you have, and alert your doctor to the likelihood of a possible future hospital admission. The clinical team at the surgery will use the information to help you get early care and treatment where it is needed.

The information will be seen only by qualified health workers involved in your care. NHS security systems will protect your health information and patient confidentiality at all times.
If you don't want your information being used in this way please tick the box below.

NO ☐

You can change your sharing preferences at any time – just speak to a member of staff.

Full Name..... Date of Birth.....

Signed..... Date.....

STAINLAND ROAD MEDICAL CENTRE

PATIENT QUESTIONNAIRE UPDATE

Please complete the information below and hand the form to reception

This information is for surgery use only and will not be released to any third party

Any Current Medical conditions ……

……

Are you currently undergoing treatment for Cancer Y/N……If yes please give details……..…….

……

Please list all current Medication ……..…….

……

Any major operations and dates ……

……..

Allergies Please list any allergies you have ……

……

FEMALES ONLY
Have you ever had a cervical smear test Y/N. …….. If so when ……..

Height and weight

Your height:	Your weight:

Smoking Status

Current smoker		How many per day?	
		Would you like information or support to stop smoking?	
Never smoked			
Ex smoker		How many a day did you smoke?	
		Date stopped smoking?	

Please tick as appropriate

We advise all smokers to cease smoking and attend a smoking cessation service.
If you would like any help with this please tick the box and we will contact you. ☐

Carers

Do you look after someone who is ill, frail, disabled or mentally ill? Y/N ……..

If yes please enter the name of the person you care for .....

Does someone look after you? Y/N ……..

Blood pressure

If you have not had your blood pressure checked recently, please speak to the doctor or nurse during your appointment.

Alcohol Intake

(Circle relevant answer)	0	1	2	3	4
How often do you have a drink that contains alcohol?	Never	Monthly or less	2—4 times per month	2—3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1—2	3—4	5—6	7—9	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a elative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year

Thank you for your help

The information given will be used solely to update your medical records and for no other purpose.