Welcome to Holderness Health. Please help us by filling in this questionnaire as it may take some time for your previous medical records to reach us. The information you provide is essential to help us with your future treatment.

We would ask that you use the enclosed practice leaflet to familiarise yourself with details of the Practice.

If you have any queries please do not hesitate to contact Reception. All the information on this form will be treated as strictly confidential.

Thank you for your assistance.

**PERSONAL DETAILS**

**Full Name**: **Date of Birth**:

**Address**:

**Postcode**:

**Home Telephone Number**: ………………………………………………………………………………..

**Work Telephone Number**: ………………………………………………………………………………..

**Mobile Telephone Number**: ………………………………………………………………………………..

**Email address**: ………………………………………………………………………………………………..

**Patient Consent for Text Messaging Appointment Reminders**:

* I consent to the Practice contacting me by text message for appointment reminders and clinics
* I acknowledge that appointment reminders by text are an additional service and these may not take place on all/or on any occasion, and that the responsibility of appointments or cancelling them still rests with me. I can cancel the text message facility at any time
* The Practice does not offer a reply facility to enable patients to respond to the sent text message directly
* The Practice will not transmit any information which would enable an individual patient to be identified.
* I agree to inform the Practice if my mobile number changes or if it is no longer in my possession
* I would like to be involved in the Holderness Health Patient Participation Group Y/N

**Patient signature**: ………………………………………………….. **Date**: …………………………….

**Name & address of previous doctors’ surgery:**

**Lifestyle:**

**MEMORY**

Do you have any concerns that your memory may not be as good as it used to be YES / NO

and causing you problem?

If YES would you like to see one of our trained staff? YES / NO

**ALCOHOL CONSUMPTION**

How many units of alcohol do you drink per week? ……………………………

Would you like further advice about services available to help you with your alcohol consumption? □

**HEIGHT / WEIGHT**

What is your height? ................................................ What is your weight? …………………………

**EXERCISE** None/light/moderate/heavy

Would you like further advice about services available to help with exercise? Yes/No

**SMOKING STATUS**

Never smoked □ Current smoker □ if so, how many per day? ………………………

Would you like further advice about services available to help you to stop smoking? □

Ex-smoker □ Approximate date stopped smoking ……………………………………………..

Would you like further advice about services available to help you stop smoking? □



**DISABILITIES**

Do you have any disabilities:

Hearing impaired □

Registered blind or partially sighted □

Speech problems □

Other disability □ Nature of disability…………………………………………………………….

…………………………………………………………………………………………………………

**VETERANS**

Are you an armed forces veteran? YES / NO

If YES would you wish to access the armed forces veteran services? YES / NO

**FAMILY HISTORY**

Have any of your immediate family i.e. father / mother / sister / brother suffered from:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ASTHMA | □ | HIGH CHOLESTEROL | □ | DIABETES | □ |
| BREAST CANCER | □ | HIGH BLOOD PRESSURE | □ | STROKES | □ |
| BOWEL CANCER | □ | HEART ATTACK/ANGINA | □ |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | ⁭ |
|  |  |  |  |  | ⁭ |
|  | ⁭ |  | ⁭ |  |  |

If you take any medicines, please bring the list from your previous surgery to the dispensary.

If this is not available, please fill in the table below. An example is filled in for you.

|  |  |  |
| --- | --- | --- |
| Drug Name | Drug Strength | How many and how often |
| *Example* | *250mg* | *One, twice a day* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

**MEDICATIONS**

**If you take any medications please supply a copy of your last prescription or bring in your labelled medication box(es).**

**CARERS**

Do you need / have anyone who looks after you or your daily needs as a Carer? Yes / No

If “Yes” would you like them to deal with your health affairs here? Yes / No

Please provide carers details:

Name: …………………………………………………………………………………………..

Address: …………………………………………………………………………………………...

Postcode: …………………………………………

Contact telephone number/s:

Home: …………………………………………. Mobile: ………………………………………………..

Work: …………………………………………..

Do you care for anyone else? Yes / No

**If you need any support please ask to see our Community Link Worker to signpost you to the appropriate service.**

Are you housebound Yes/No

Are you a carer or cared for Yes/No

**NEXT OF KIN**

Please provide NOK details:

Name: …………………………………………………………………………………………..

Address: …………………………………………………………………………………………...

Postcode: …………………………………………

Contact telephone number/s:

Home: …………………………………………. Mobile: …………………………..

|  |  |
| --- | --- |
| **ETHNICITY** What is your ethnic group? (please tick) | |
| **WHITE**  □ British  □ Irish  □ Any other white background | **BLACK OR BLACK BRITISH**    □ Caribbean  □ African  □ Any other black background |
| **ASIAN OR ASIAN BRITISH**  □ Indian  □ Pakistani  □ Bangladeshi  □ Any other Asian background | **MIXED**  □ White and Black Caribbean  □ White and Black African  □ White and Asian  □ Any other Mixed background |
| **CHINESE OR OTHER ETHNIC GROUP**  □ Chinese  □ Any other Mixed background | **DO NOT WISH TO STATE**  □ Not stated |
| *The ethnic origin categories are those used in the 2001 Census (Office of Population Censuses and Surveys) and are recommended by the Commission for Racial Equality and the Bar Council* | |
| Do you speak / understand English? Yes / No  Do you require an interpreter? Yes / No | |