Oakview Family Practice (Adult Patient Questionnaire)

It is of enormous benefit to the Doctor to know something about your medical background when you come to the surgery. We may not receive your medical records for sometime and it enables us to provide you with a better service if you are willing to provide us with some information about your health.

NAME: **DATE OF BIRTH:**

Please indicate if you have a personal history or close family history of any of the following medical conditions

	You (please include year of diagnosis if you know)	Your close family (please note which relative
Angina		
Heart Attack		
High cholesterol		
Asthma		
COPD		
Diabetes		
High blood pressure		
Cancer (if so what type)		
Epilepsy		
HIV		

Do you have any difficulties with communication? (Please include visual or hearing impairments, learning difficulties and dementia)

Have you ever suffered from? (Please circle as appropriate)

Depression Yes / No Anxiety Yes / No

Schizophrenia Yes / No Bipolar disorder Yes / No

Please list any other illnesses, injuries or operations (with dates)

Please list any regular medications you take including herbal remedies and the amount (or attach repeat prescription tear off)

Are you allergic to any drugs? Please give details.

Are you housebound? Yes / No

Are you a carer? (Do you look after a vulnerable adult or child with special needs) Yes / No

Do you have a carer? Yes / No

At Oakview Family practice we encourage all our new patients to be tested for HIV
Would you like an HIV test? Yes / No

Would you like to be provided with a self-testing kit for sexually transmitted infections (For women this will be a self-swab and a urine specimen for men)
Yes / No

LIFESTYLE:
Would you like advice on services that help with increasing physical activity and/or weight management? Yes / No

Do you smoke?
Yes / No / Ex-smoker If yes, how many per day? ……

Would you like information on stop smoking services available? Yes / No

Alcohol
1 unit = half-pint of regular beer, lager or cider or 1 small glass of wine or 1 single measure of spirits (25ml)

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	
A TOTAL OF 5 OR MORE SUGGEST HARMFUL DRINKING					**TOTAL**	

Would you like advice on services to help reduce your alcohol intake? Yes / No

WOMEN'S HEALTH
When was your last smear test?
Where the most recent results; Normal ☐ Abnormal ☐ Other ☐ please state……

Ethnicity……First language……

Next of Kin…….....Tel:…….

Signed:…….. Date:……..

For Staff Use Only: ID VERIFIED TYPE:……BY……..

OFP Authorization……..