Patient Questionnaire

MANOR FARM
MEDICAL CENTRE

Mangate Street, Swaffham. Norfolk. PE37 7QN

Contact Details

Full Name inc Title:		Full Home Address:	
Date of Birth:		Occupation:	
Contact Details:		Next of Kin:	
Home		Name	
Mobile		Relationship to you	
Email		Contact Number(s)	

Nationality and Ethnic Origin

Nationality:		Do you require an interpreter?	YES	NO

Ethnic Origin: Please tick relevant box or let us which Ethnicity you are.

White		Black Caribbean	
Asian		Black African	
Chinese		Traveller	

Other:

If you were born in another Country, what date did you enter the UK? **Please bring your passport as proof of ID**	

Accessibility Information

As a practice we have a duty of care to our patients to ensure they are able to read and understand all information we send out. If you have difficulties reading our letters or need someone to support you during appointments, please let us know by ticking the relevant boxes below.

Braille		Large Print		Easy Read		Sign Language		Interpreter	
Hard of Hearing		Other:							

Text Messaging Service

We offer our patients a text messaging service to receive Mobile phone messages and or Emails with appointment reminders and any other relevant information.

If you wish to opt out of this service please tick the box. ☐

We also require proof of Identity and Address. This can be, Birth Certificate, Driving Licence, Passport, Utility Bill, Offer of Tenancy. If there is a name change we will require proof.

Permission for other person(s) to access your medical records

I give permission for the practice to communicate with the person(s) named below in regards to my records.

Person 1

Full Name	Gender
Address	Tel No

Relationship to Patient	

Please tick all boxes that apply

Emergency Contact	YES	NO	Can discuss records	YES	NO	Test Results Only	YES	NO

Specified time period only	YES	NO	If yes, please state length of time
Making/cancelling appointments	YES	NO	

Person 2 (if applicable)

Full Name	Gender
Address	Tel No

Relationship to Patient	

Please tick all boxes that apply

Emergency Contact	YES	NO	Can discuss records	YES	NO	Test Results Only	YES	NO

Specified time period only	YES	NO	If yes, please state length of time
Making/cancelling appointments	YES	NO	

Permission for children under 16

Everyone aged 16 or over is presumed to be competent to give permission for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable them to understand fully what is proposed” then they will be competent to give permission for themselves.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign the Permission Form for themselves, but may wish someone with partial responsibility to countersign as well.

If the child is not able to give permission for themselves, someone with parental responsibility should do so on their behalf by signing the form below.

I am:	Parent / Guardian with parental responsibility

Full Name:

Address if different from patient:

Signature:

Carer or Cared for

Are you being Cared for? if yes please give details below (tick appropriate box)	Yes		No	

Name:	DoB:
Tel No:	Relationship to you:

Are you a Carer? If so please give details below.

Medical Information

Height:	Weight:	Date Last Weighed:

Diet: *Please tick all the apply*		Exercise: *Please tick all the apply*	
Low Fat		Intensity	Length of time
Low Carb		Light i.e slow walking, light gardening, slow swimming	
Vegetarian		Moderate i.e Brisk walking, mowing lawn, riding bike on level ground	
Vegan		Vigorous i.e, Jogging or running, swimming fast, biking fast uphill	
Other: Please specify			

Smoking: ***(includes - cigarettes/hand rolled/cigars/pipe) please state how many you smoke daily***

Current Smoker	Qty	Ex Smoker	Qty & Date stopped	Never Smoked	Please tick

Have you been offered Smoking Cessation Advice?	Yes	No	If Yes, please enter the date of Advice given	Date:

Are you a passive smoker? (Someone smokes in your home)	Yes		No	

Alcohol: ***Please circle the relevant answer***

How often do you have an Alcoholic Drink	**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 - 8	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost daily

Current or Past Diseases

Please circle any of the following diseases that apply to you and circle if Current or Past.

Angina	Current		Diabetes	Current		Stroke	Current	
	Past			Past			Past	
Asthma	Current		Epilepsy	Current		Thyroid Disorder	Current	
	Past			Past			Past	
Cancer of:	Current		Heart Attack	Current		Other Give details below	Current	
	Past			Past			Past	
COPD	Current		High Blood Pressure	Current				
	Past			Past				
Coronary Heart Disease	Current		Rheumatic Arthritis	Current				
	Past			Past				

Medical Information continued

Are you currently or in the past suffered from any of the following: **Anxiety, Depression, Bipolar Disorder, OCD**. If yes, please state below which one and when you were first diagnosed.
Do you have any other mental health issues? (if yes, please give details)
Are you receiving or have you received any treatment or therapy? (if yes please give details of your care and when received)

For patients aged 65 and over or those with a chronic disease (e.g Asthma or diabetes)

Have you had a flu vaccination	Yes	No	If yes, enter date, if no a brief reason why

Have you had a pneumococcal vaccination	Yes	No	If yes, enter date, if no a brief reason why

If you are currently taking regular medication, please attach your repeat slip to this form.				
At the practice we have an Anti-Coagulation Clinic. Are you taking Warfarin?	Yes		No	
Do you regularly take over the counter medication? i.e Aspirin, heart burn relief etc. If yes, please briefly explain why	Yes		No	
Do you have any allergies? (ie medication/food/plants)	Yes		No	

Family History

Please state if any close family members have any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes, asthma or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

Female Patients Only

Have you had any of the following:
Children, Miscarriage, Termination of Pregnancy, Hysterectomy. If yes, please give details below

When was your last Smear Test?	Date:	Result:
If you are aged 25 or over and never had a Smear test, please explain why		

Thank you taking the time to complete this form.