NHS

Five Oaks Family Practice –Questionnaire

Please use BLOCK CAPITALS and answer all questions. The information provided will form part of your medical record.

If you are returning from the **Armed Forces,** please let us know.

Personal Details

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐

2. Male ☐ Female ☐

3. Surname _____
_____

4. First names: _____
_____

5. Previous surname(s): _____
_____

6 Date of birth: ____/_____/_____
(day) (month) (year)

7. NHS number _____
_____
(if known)

_____

8. Town and
Country of birth: _____
_____

_____

9. If you are from abroad, the date you came to the UK _____

10. Current Manchester address:

Postcode

11. How long will you be at this address?
Less than 6 months ☐ More than 6 months ☐

12. Home telephone:

13. Work telephone:

14. Mobile telephone:

15. Email:

Previous GP

16. Have you **ever** been registered with a GP in the UK? Yes ☐ No ☐

17. Name and address of last GP/Surgery:
_____

18. Your address while registered with previous GP:
_____

Your next of Kin/Emergency Contact

19. Next of kin's name: _____
_____

20. Relationship to you: _____
_____

21. Next of kin's address:
_____

22. Telephone number:

Your Ethnic Group

23. Please chose one of the five sections and then tick your ethnic group:

(Please tick one box only) These ethnic group descriptions are a national standard taken from the 2001 census	**White** ☐ White British ☐ White Irish ☐ Other White – please write in:	**Mixed** ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed – please write in:
Asian or Asian British ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian – please write in:	**Black or Black British** ☐ Black Caribean ☐ Black African ☐ Somali ☐ Other Black – please write in:	**Chinese or other** ☐ Chinese ☐ Middle Eastern ☐ Any other – please write in:

Do you need an interpreter for your appointments? Yes ☐ No ☐

My main spoken language is

_____

Sexual Orientation

24. Which of the following best describes you?

Lesbian/Gay ☐ Bisexual ☐ Heterosexual/Straight ☐

Your Medical History

25. Please put a tick in the box of any medical conditions/disabilities **you** have.

Heart problems ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Thyroid problems ☐

COPD ☐ Cancer ☐ Stroke ☐ Mental health i.e. depression ☐ Epilepsy ☐

Other ☐

26. Do you have a Learning Disability? Please fill in a separate questionnaire which is available at Reception) Yes ☐ No ☐

Medication

27. Do you take regular medication? Yes ☐ No ☐

List below any medication you are taking or attach a copy of your repeat prescription.

Name	Dose	Frequency

PLEASE MAKE AN APPOINTMENT TO SEE THE GP FOR YOUR FIRST REPEAT PRESCRIPTION

Lifestyle

28. Are you a main carer (unpaid) for someone who has poor health or disability? Yes ☐ No ☐

29. Do you smoke? ☐ Never smoked ☐ Smoker = cigarettes per day _____ Ex-smoker ☐

30. Do you drink alcohol? Yes ☐ No ☐

31. If yes, how often do you have a drink containing alcohol?

Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week ☐

Alcohol units: Pint of beer/lager/cider = 2, Single spirits (25ml) =1, ~Glass of wine (175 ml) = 2, Alcopop = 1.5

32. How many units of alcohol do you drink on a typical day when you are drinking?

1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 10+ ☐

33. How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year?

If you are worried about your alcohol consumption please make an appointment to see your GP

34. Height_____ 35. Weight _____

36. Allergies

_____

37. Smear (**women and trans people with cervixes over the age of 25)**

Date of last smear test _____ Place taken _____

Result _____ When smear next due _____

Students – over 16 only

Education

38. Are you currently a full time/part time student aged 16 and over in Further education or University?
Yes ☐ No ☐

If yes have you received 2 doses of MMR vaccine? Yes ☐ No ☐

If not please make an appointment with the Practice Nurse to receive the same

Complete this section for children under 16

Childhood immunisations

39. Are you filling this form in for a child under 16? Yes ☐ No ☐

If yes is the child up to date with their immunisations? Yes ☐ No ☐

Did your child receive their immunisations in the UK? Yes ☐ No ☐
If yes please state which area

_____

Did your child receive their immunisations abroad? Yes ☐ No ☐
If yes please state which Country

_____

If you have a copy of your child immunisation record, please hand this in with your child's registration form

Parents details

40. Is either of your parents: (please put a tick in the box that applies to you)

	Father	Mother
In full time Employment	☐	☐
Part time employment	☐	☐
Unemployed	☐	☐

Children aged 0-3 ½ years old

41. Please underline which of the following applies to your child's day care?

Looked after by Parent Relative Friend Nursery Playgroup

Name of day care provider

_____

Contact number

_____

Children aged 3 ½ - 16 years old

42. Is your child attending school? Yes ☐ No ☐

Name of school your child attends _____ Contact number ___

_____

If your child is not attending school, please state the reason why

_____

Childcare arrangements

43. Who looks after your child before and after school? Name

_____

Contact number

_____

Please underline which of the following applies: Parent Relative Friend Nursery

Playgroup Before/After school club