***Rolle Medical Partnership***

***Patient Health Questionnaire for Adults***

***Accessible information standard-If you require this information in a different format or communication support please let us know by completing the section on page 4.***

*Thank you for registering with our Practice. To enable us to give you the best possible care while we are waiting for your medical records to arrive from your previous Doctor, please would you spare a moment to complete this brief form and hand back to the Receptionist*.

|  |  |  |
| --- | --- | --- |
| Title …… | Surname ……………………………… | First Names ………………………………… |
| Date of birth ………………. | Previous Surnames ………………………………………………….. |
| Occupation ………………………………………….. | Home Tel …………………………………... |
| Home Address ………………………………………………………...…………………………………………………....…...………………………………………………...............Post Code ……………………………………………..  | Work Tel ………………………………….... |
| Mobile ………………………………........... |
| Email ………………………………………. |
| ***Please note: As a reminder, we might send a text message to your mobile phone if you have an appointment with the doctor. If you do not wish to receive this service, please let us know.*** |
| *Information about you* |  |
| What is your first language? ………………….………………………………….. |
| ***Ethnic group*** | If ‘other’ please specify |
| *White* | ⁭ British | ⁭ Irish | ⁭ Other  | ..…………………...... |
| *Black* | ⁭ Caribbean | ⁭ African | ⁭ Other | ……………………… |
| *Asian* | ⁭ Indian | ⁭ Pakistani | ⁭ Chinese | Other ⁭ …………… |
| *Mixed* | ⁭ White + Black Caribbean | ⁭ White + Black African |  |
| ⁭ White + Asian | ⁭ Other |  |
| *Previous GP* |
| Name and address of previous GP | …………………………………………………………………………..……………………………………………………………………………………………….. |
| *Medical information* |
| Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place:………………………………………………………………………………………………………………..………………………………………………………………………………………………………………..……………………………………………………………………………………………………………….. |
| Have you ever suffered from? (tick as appropriate) |
| Epilepsy | ⁭ Yes | ⁭ No | Blindness/Glaucoma | ⁭ Yes | ⁭ No |  |
| High Blood Pressure | ⁭ Yes | ⁭ No | Diabetes | ⁭ Yes | ⁭ No |
| Heart Attack/Stroke | ⁭ Yes | ⁭ No | Depression | ⁭ Yes | ⁭ No |
| Cancer | ⁭ Yes | ⁭ No | Asthma | ⁭ Yes | ⁭ No |
| Eczema/Hay Fever | ⁭ Yes | ⁭ No | COPD | ⁭ Yes | ⁭ No |
| Please attach a copy of your current repeat medication slip or list any medicines being taken and the amount: |
| ………………………………………………………………………………………………………………………………………………………………………………………………………………………………Which chemist would you like us to send your prescription to? (tick as appropriate)Clarepharm Withycombe Lloyds Budleigh (Large)Boots Pines Lloyds Budleigh (Small)Jhoots Rowlands Whites Lewis Tesco Other ………………………… |
| Are you registered disabled? If ‘yes’, please give details.  | ⁭ Yes ⁭ No |
| ……………………………………………………………………………………………………………………………………………………………………………………………………………………………… |
| Do you have any allergies? If ‘yes’, please give details. | ⁭ Yes ⁭ No |
| ……………………………………………………………………………………………………………… |
| Have you ever refused treatment/screening of any kind and if so, what?  | ⁭ Yes ⁭ No |
| ……………………………………………………………………………………………………………… |
| *Carers* |  |  |
| Do you have a carer? If ‘yes’ please give details  | ⁭ Yes ⁭ No |
| ……………………………………………….................................................................................................. |
| Are you a carer? (If ‘yes’ please give details)  | ⁭ Yes ⁭ No |
| …………………………………………………….......................................................................................... |
| *Will* |  |
| Do you hold a Living Will? | ⁭ Yes ⁭ No |
| *(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)* |
| *Women* |  |  |
| Have you ever had a cervical smear? | ⁭ Yes ⁭ No |
| *Smoking* |  |  |
| Do you smoke? | ⁭ Yes ⁭ No |
| If ‘no’, have you ever smoked? | ⁭ Yes ⁭ No |
| If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week? ……… |
| Would you like advice on giving up smoking? | ⁭ Yes ⁭ No |
| *Alcohol**Patient:* Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.Please place an X in one box that best describes your answer to each question. |  |
| **Questions** | **0** | **1** | **2** | **3** | **4** |  |
| 1. How often do you have a drink containing alcohol?
 | Never | Monthly or less | 2 - 4 times a month | 2 – 3 times a week | 4 or more times a week |  |
| 1. How many drinks containing alcohol do you have on a typical day when you are drinking?
 | 1 or 2 | 3 or 4 | 5 or 6 | 7 or 9 | 10 or more |  |
| 1. How often do you have six or more drinks on one occasion?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. How often during the last year have you found that you were not able to stop drinking once you had started?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. How often during the last year have you failed to do what was normally expected of you because of drinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. How often during the last year have you had a feeling of guilt or remorse after drinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. How often during the last year have you been unable to remember what happened the night before because of your dinking?
 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 1. Have you or someone else been injured because of your drinking?
 | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| 1. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?
 | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

|  |  |  |
| --- | --- | --- |
| *Height and Weight* |  |  |
| What is your height? …………………………….. | What is your weight? ………………………… |
| *Family History* |  |  |
| Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |
| *For patients aged 65 and over* |
| Please give name, address and telephone number of next of kin…………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |
| *For patients aged 65 and over or those with a chronic disease (eg asthma or diabetes)* |
| Have you had a flu vaccination? Enter date or ‘never’ ………………………………………………….. |
| Have you had a pneumococcal vaccination? Enter date or ‘never’ ………………………………………Have you had a shingles vaccination? Enter date or ‘never’……………………………………………… |
| ***Signature ………………………………………………..................................*** |

***Accessible information standard -If you require information in a different format or communication support, please indicate by ticking a box below your preferred format and we will add this to your records.***

□ By Telephone By British Sign Language

 By letter Information in Makaton

By email Information in uncontracted (Grade 1) Braille

 By short message service text message Information in contracted (Grade 2) Braille

 Contact via carer Written information in large font

 By loud verbal communication Written information in at least 20 point sans serif font

 By Text relay Written information in at least 24 point sans serif font

 By contact via telephone interpreting line Written information in at least 28 point sans serif font

Signature………………………………………..Date……………………………………………………….

Contacting You

**I agree that I may be contacted from time to time, via email and / or SMS, with practice news, advice about my health and / or appointment reminders**

**Signature**

**Date**

# ONLINE SERVICES

We have introduced a new ‘online’ service for our patients. This is accessed via our website [www.rollemedicalpartnership.co.uk](http://www.rollemedicalpartnership.co.uk) - by clicking on the ‘online services’ link.

Here you will be able to book appointments with GPs, order repeat prescriptions and submit questions to the practice.

You need to register for this service in person at the practice.

**Patient Consent Form**

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether or not you wish us to share the information that we have recorded about you within your patient record. You have the right to withdraw consent at any time and also to change who you wish us to share your information with. Should this be the case, we will inform the relevant partner organisations and advise them of your decision.

I, ………………………………………………… (Print Name) , D.O.B……………., give/do not give (delete as appropriate) consent for my information to be shared to discuss the care that is provided to identify services and resources which could support my health and wellbeing.

For further information on who we share with and what steps we take to protect the information we hold, please see our Fair Processing (Privacy) Notice.

Please tick against each data set identifying if you wish/do not wish to share data

|  |  |  |
| --- | --- | --- |
| Record Sharing Initiative | I hereby give consent for my information to be shared. | I do not consent for my information to be shared. |
| Summary Care Record |  |  |
| Care.Data |  |  |
| Local Shared Care Record (local providers only) |  |  |
| Consent for this organisation to view data that is recorded at other care services |  |  |

**For Staff Use Only**

Please ensure that the referring organisation is removed from the list of options above.

Ensure that a copy is provided to the patient, stored in the paper medical record and shared with the appropriate organisations. Should the above named patient indicate that they wish to amend the organisations that they have onsented to share with or that they have withdrawn consent completely, please ensure that a new form is completed with the revised choices and then share and store as previous.