PETROC GROUP PRACTICE

DRS PRIEST,MACKINNON,BROWN,BLAKE,JAIN,DERRY,JENKINS,SMITH & MR I GIBSON

Welcome to your new medical practice. To help us improve service, we would appreciate your time in completing this form. Please answer the following questions as accurately as you are able.

MR ☐ MRS ☐ MISS ☐ MS ☐ FULL NAME ……...

ADDRESS ……...

…… POSTCODE ……..

TELEPHONE (Home) …… (Mobile) …….

WORK NUMBER ……. EMAIL ADDRESS ……

DATE OF BIRTH ……/……/……... MARITAL STATUS …….……OCCUPATION ……...……...

NEXT OF KIN …… RELATIONSHIP……

ADDRESS…… CONTACT NUMBER ……

MAIN SPOKEN LANGUAGE: ENGLISH YES ☐ NO ☐ - IF NO PLEASE SPECIFY …….....

ARE YOU ON A WAITING LIST FOR ANY SORT OF OPERATION? YES ☐ NO ☐

IF YES, WHAT OPERATION ARE YOU WAITING FOR? ……...

AT WHICH HOSPITAL ARE YOU ON A WAITING LIST? ……..

ARE YOU CURRENTLY BEING SEEN BY A CONSULTANT? YES ☐ NO ☐

IF YES, WHERE? …… WHAT FOR? ..……..

WHAT IS YOUR WEIGHT? …… WHAT IS YOUR HEIGHT? ..…….

SMOKING STATUS? NEVER SMOKED ☐ EX-SMOKER (Date Stopped)……..

CIGS PER DAY…….....… IF YOU WOULD LIKE HELP GIVING UP PLEASE ASK RECEPTIONIST

HOW MUCH ALCOHOL (IF ANY) DO YOU CONSUME EACH **WEEK**? …….

WHAT WAS THE DATE OF YOUR LAST TETANUS INJECTION? ……...

DO ANY ILLNESSES RUN IN YOUR FAMILY? e.g. Diabetes, Epilepsy, Heart Disease YES ☐ NO ☐

IF YES, WHAT ARE THEY? ……

DO YOU CONSIDER YOURSELF TO HAVE A LONG TERM DISABILITY? YES ☐ NO ☐

PLEASE LIST ANY SERIOUS ILLNESSES OR OPERATIONS BELOW

DATE	NATURE OF ILLNESS

DATE	NATURE OF ILLNESS

PLEASE LIST ANY KNOWN **ALLERGIES**
(eg, penicillin, peanut)

Please tick here if you are on **repeat medication** ☐

If you are, please bring a copy of your repeat card
Non-dispensing patients: Where would you like to collect your medication: Surgery or Chemist –please name

(Continued on back)

ARE THERE ANY OTHER POINTS IN YOUR PAST HEALTH RECORD WHICH YOU WOULD LIKE TO BRING TO YOUR DOCTOR'S ATTENTION AT THIS TIME? …….

……...

COMMUNICATING WITH YOU
DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS? WHAT COMMUNICATION SUPPORT SHOULD WE PROVIDE FOR YOU? PLEASE LET THE RECEPTIONIST KNOW IF YOU NEED ANY COMMUNICATION SUPPORT FROM US.

……...

ETHNIC GROUP (Please Tick)			
White	British	☐	
	Irish	☐	
	Cornish	☐	
	Any other white background (please write in)	☐	
Mixed	White and Black Caribbean	☐	
	White and Black African	☐	
	White and Asian	☐	
	Any other mixed background (please write in)	☐	
Asian or Asian British	Indian	☐	
	Pakistani	☐	
	Bangladeshi	☐	
	Any other Asian background (please write in)	☐	
Black or Black British	Caribbean	☐	
	African	☐	
	Any other Black background (please write in)	☐	
Chinese or other Ethnic Group	Chinese	☐	
	Any other (please write in)	☐	
PREFER NOT TO SAY		☐	

FEMALE PATIENTS ONLY

HAVE YOU EVER HAD A SMEAR? YES ☐ NO ☐

IF YES, PLEASE GIVE DATE OF LAST SMEAR ……/…../……..

RESULT, if known …….

WHICH CONTRACEPTIVE METHOD, if any, DO YOU USE? (Please Tick)

PILL ☐ I.U.C.D. (Coil) ☐ DIAPHRAGM (Cap) ☐ OTHER ☐

IF THE PILL IS USED, WHICH ONE? ……

PLEASE GIVE DATES OF THE FOLLOWING IMMUNISATIONS:

PRIMARY COURSE

1st ……/……/…….. 2nd ……/……/…….. 3rd ……/……/……..

HIB & MENINGITIS C ……/……/…….. (12 months)

MMR & PNEUMOCCAL / / (13 months)

PETROC GROUP PRACTICE
HEALTH QUESTIONNAIRE

MR • MRS • MISS • MS •

FULL NAME ……...

ADDRESS……...

…… POSTCODE ……..

TELEPHONE (Home) …… (Mob) ……

DATE OF BIRTH ……/……/……...

DO YOU HAVE ANY OF THE FOLLOWING CHRONIC DISEASES IF SO PLEASE GIVE DETAILS.

CHRONIC OBSTRUCTIVE PLUMONARY DISEASE

……

ASTHMA

……

CORONARY HEART DISEASE

……

DIABETES

……

HYPERTENSION

……

If you have any other information regarding your conditions, please attach to this Questionnaire

FAST FORM

Name:

DOB:

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Monthly (1) or Less than monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

If score is 0, 1 or 2 on the first question then continue with the next three questions.
If score is 3 or 4 on the first question – stop here. This indicates FAST positive.

An overall total score of 3 or more (on the first question or all four questions) is FAST positive.

What to do next?

If FAST positive, please make an appointment to see a Doctor to discuss your alcohol consumption further.