

# Southwood Practice

## PATIENT QUESTIONNAIRE & HEALTH CHECK (Please complete in black ink)

Date: ..... Title: Mr / Mrs / Miss / Ms / Other.....

Surname: ..... Forenames: .....

Previous surname: ..... Mother's Maiden name: .....

Have you been registered with Southwood Practice before? NO YES (please circle)

Sex: Male Female (circle) Date of Birth: .....

Address: .....

Ethnic Origin: ..... Place of Birth: .....  
eg White British, Indian, Chinese, White European

First Language: ..... Second Language: .....

If you need a language or BSL interpreter for your appointments please tick

Home Phone No: ..... Mobile Phone No: .....

E-mail: .....

Your Occupation: ..... Are you a military veteran? Y / N

Next of Kin – Name and Tel No: .....

Relationship to you: .....

Are you a carer for a physically disabled child or adult? Yes No (circle)

If yes please ask at reception for a carer registration pack.

Height: ..... Weight: .....

### Smoking History

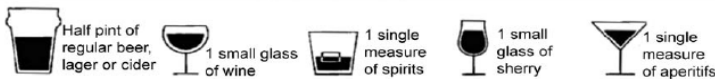
Do you smoke?  How many per day? .....

Have you ever smoked? No Yes (Please circle)

If yes, how many per day? .....When did you give up?.....

Do you use a vape/electronic cigarette? No Yes

### Alcohol Consumption



How many units of alcohol do you drink per week? .....

### Exercise (please tick)

Exercise impossible  Avoid Exercise  Light Exercise

Moderate Exercise  Heavy Exercise  Competitive Athlete

### Diet (please tick)

Vegetarian  Vegan  Weight Reducing  Low Fat

Low Salt  Milk Free  High Fibre  Normal

**Please inform us if you have any diagnosed mobility or disability that may effect you attending the surgery in person?**

.....

**Past Medical History**

Only document any relevant illnesses e.g. operations, diabetes, asthma, stroke, heart disease, tumours, psychiatric illness etc.

.....

**When was your last cervical smear?**.....**Result** .....

**Current Medication** (Please attach computer repeat request form from your last practice) (**Note: If you are on any regular medication you will need to book an appointment with one of our GPs**)

.....

**Allergies**

.....

**Family Medical History      Family Member      Age When Diagnosed**

Ischemic Heart Disease		
Heart Attack/Angina		
Stroke		
High blood pressure		
Diabetes		
Asthma		
Cancer		

**Vaccinations:** Please list all vaccinations you can remember particularly Tetanus/Polio/Travel.

**Vaccinations:** ..... **Approximate Dates:** .....

.....

GP Practices will upload some your data to NHS departments as part of its NHS contract to those mentioned below; if you **do not** want to have your medical information uploaded please indicate below (further information is found on our website):

Hampshire Health Record       HSCIC       Summary Care Record

Please tick if you wish to **opt IN** to receiving appointment reminders via      text      email

**Have you nominated a pharmacy to receive your electronic prescriptions?**  
**If YES you will need to notify your nominated pharmacy that you have moved.**

**ONCE THE FORM HAS BEEN COMPLETED, PLEASE TAKE TWO BLOOD PRESSURE READINGS FROM THE MACHINE OUTSIDE THE TREATMENT ROOM—PLEASE ASK RECEPTION IF YOU NEED ASSISTANCE.**

**Signature:** .....

**Print Name:** .....

**Date:** .....

<p><b>Office Use Only:</b>            Type of ID seen:.....</p> <p>Last 4 digits of ID seen .....</p> <p><b>Staff Initials:</b>            Received by .....</p> <p>Entered on to EMIS .....</p>
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# Opt In/Out Patient Choice Form

For more information on data sharing please see our web site under GDPR and also [www.nhsdatasharing.info](http://www.nhsdatasharing.info).

Please tick the following if you wish to **OPT-IN**

To receive SMS text reminders for appointments and/or health promotion information (from Southwood Practice only)

To receive email health promotion information (from Southwood Practice only)

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## IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORD (Please read carefully)

The NHS shares data from your medical record in a number of ways. You have the right to control how your personal information is used and who has access to it. You can opt out of this data sharing by completing the form below. We will then add relevant coding to your record to stop the extraction and processing.

**I DO NOT wish for any information to be extracted and uploaded from my GP record for the following purposes: (Please tick those below where you wish to OPT-OUT).**

### National Data Opt-Out

Please Opt me out of this section *Office use: Code - 9Nu0 Dissent from secondary use and NSOO (9Nu4 no longer valid from 25/5/18)*

### The Summary Care Record

Please Opt me out of this section *Office use: Code - 9Nd0 express dissent from SCR upload*

### Clinical Data Repositories/Warehouses

(e.g. The Hampshire Health Record, Connected Care, The Manchester Care Record, The Stockport Health and Care Record, The Salford Integrated Record, The Cheshire Care Record, The North Staffs/Stoke-On Trent Shared Record)

Please Opt me out of this section *Office use: Code - 9Nd1 no consent for electronic record sharing*

### Risk Stratification (a secondary use of your information)

Please Opt me out of this section *Office use: Code- 9Nu0 Dissent from secondary use (as appropriate)*

Please ensure that no further information is uploaded about me. I understand that I can opt back in to any or all of these databases at any time in the future by informing the Practice in writing.

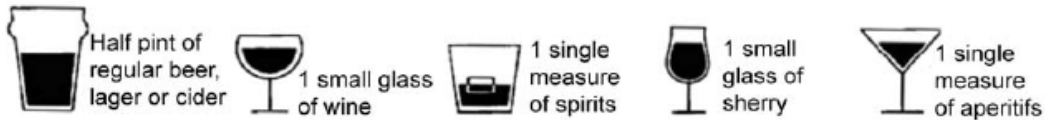
**ONLY SIGN HERE IF YOU HAVE TICKED ANY OR ALL OF THE BOXES ABOVE**

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name.....

DOB:.....

## This is one unit of alcohol...



## ...and each of these is more than one unit



## AUDIT – C

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	

### Scoring:

A total of 5+ indicates increasing or higher risk drinking.  
An overall total score of 5 or above is AUDIT-C positive.



## Score from AUDIT- C (other side)



## Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
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 needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
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:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals  
AUDIT C Score  
(above) +  
Score of remaining  
questions

