



Confidential Health Questionnaire

For All New Patients Aged 16 Or Over There is a balance between privacy and good health care. Unless we receive your written instructions to the contrary, we will normally share some information with other health professionals involved in your care, such as doctors, nurses, therapists and pharmacists.



About Me >>>

Surname: _____ **Forename/s:** _____ **Male** **Female** **Date of Birth:**/...../.....

Previous Surname/Maiden Name: _____ **Country of Birth:** _____

Address: _____ **Town where Born:** _____

_____ **Ethnicity:** _____

_____ **First Language:** _____

_____ **Home Telephone No:** _____

_____ **Post Code:** _____ **Work Telephone No:** _____

e-Mail Address: _____ **Mobile:** _____

Emergency Contact Name & Telephone No: _____ **Impairments or anything else we should know about?**

Relationship To You Of Emergency Contact: _____

Carer? >>>

If you are a carer then please let us know. We keep a carers register so that help and advice can be made available to assist and support you. Please tick or complete as required.

Are you a carer? Yes No **If Yes, who do you care for:**

Is the person you care for registered with our practice? Yes No **Name:** _____

Address: _____

Please tick if you do not wish this information to be passed to other organisations e.g. housing, education, Social Services

My Medical Details >>>

Please provide the information requested; if you cannot remember exact dates, then enter month and year or just year

Physical

Height:ftins Ormcm

Weight:stlbs Orkg

Do You Smoke?

I have never smoked Yes No

I smoke per day

I stopped smoking (Please enter date)

Exercise

Which of these best describes the kind of exercise you take?

Impossible **None** **Light** **Moderate**

Strenuous **Competitive Athlete**

How many times do you exercise each week?

..... (Specify)

Allergies

Have you ever had an allergic reaction? Yes No

e.g. medication, latex, insect stings, specify

Diet

Normal Diet **Diabetic**

Vegetarian **Weight Reducing**

Medical **Please specify**

Medication

Are you currently taking medication Yes No

If yes, please give details. If these are prescription only medicines, please make an appointment to see a doctor bringing all relevant documentation and information with you. A repeat prescription cannot be issued without first seeing a doctor. **Please list your medications below:**

Alcohol Consumption		Please answer the three questions below ① ② ③ by circling your choice.					For Office use Only
Questions	0	1	2	3	4		
① How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 + times		
② 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+		
③ How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		

My Medical History >>>

	Me	A Relative (state relationship)
Coronary/Ischaemic Heart Disease		
Heart Attack (Age if known)		
Angina		
Stroke (Age if known)		
High Blood Pressure (Hypertension)		
Diabetes		
Glaucoma		
Asthma		
Eczema		
Chronic Lung Disease		
High Cholesterol		
Epilepsy		
Hypothyroidism		
Cancer		
Mental Illness/Psychosis		

Have you had your blood pressure checked in the last 3 years Yes No

Have you had any recent vaccinations, for example Tetanus, Polio, Hepatitis B, Pneumococcal etc? Please indicate which and supply the dates they were administered if known:

Female Patients Only >>>

Would you like to register for contraception? Yes No

What was the date of your last cervical smear?/...../.....
 Where was the smear taken? GP Hospital Clinic

Have you ever had an abnormal smear? Yes No Date/...../.....

Have you had a hysterectomy? Yes No Date/...../.....

Have you had a mammogram? Yes No Date/...../.....
 If yes, was it normal Yes No

Have you ever been pregnant? Yes No How many times


If you use contraception, please state method:

How many children do you have?

Did You Know?

Smoking is the UK's Single Greatest Cause of Preventable Illness

Stopping smoking is not easy but it can be done and there is now a comprehensive NHS Smoking Cessation Service offering help and support to those who wish to quit. Call **0800 169 0 169** or visit **www.givingupsmoking.co.uk**



Don't give up giving up.

Patient Declaration >>>

I confirm the information provided on this form is correct and agree to the Practice terms on information sharing.

Signed

Date:/...../.....