Confidential Health Questionnaire

For All New Patients Aged 18 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:

Address:

Post Code:

e-Mail Address:

Emergency Contact Name & Telephone No:

Relationship To You Of Emergency Contact:

Country of Birth:

Town where Born:

Ethnicity:

First Language:

Home Telephone No:

Work Telephone No:

Mobile:

Impairments or anything else we should know about?

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 ☐

Is the person you care for registered with our Yes ☐ No ☐

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

If Yes, who do you care for:

Name:

Address:

My Medical Details >>>

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

Physical

Height: ......**ft** ......**ins** **Or** ......**m** ......**cm**

Weight: ......**st** ......**lbs** **Or** ......**kg**

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** ☐

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:**

How many times do you exercise each week?

.... (Specify)

Alcohol Consumption Please answer the three questions below ❶ ❷ ❸ by circling your choice.

Questions	0	1	2	3	4	For Office use Only
❶ 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	
❷ 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+	
❸ 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, Pneumoccocal 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: ...../...../.....

For staff use only. Type of ID provided: SCR Pack Issued: Checked by: