CONFIDENTIAL HEALTH QUESTIONNAIRE

Title: Miss / Ms / Mrs / Mr / Other (please state) DOB: _____ AGE: _____

Surname: _____ Forename _____

Previous Surnames: _____ Calling Name: _____

Address: _____

_____ Postcode: _____

Home Telephone: _____ Mobile: _____

Email Address: _____

Do you give permission for the surgery to contact you via Email and SMS? Yes ☐ No ☐

Marital Status: Single / Married / Cohabiting / Separated / Divorced / Widowed

Occupation / School **Name** / College **Name**: _____

Do you have a carer for your health needs? Yes / No

Name: _____ Contact No: _____

Address: _____

Do you care for someone who is ill, frail, disabled or mentally ill? Yes / No

Details: _____

Parkfield Medical Centre has a large and very successful Patient Participation Group. If you would like more information about membership, activities or anything else, please indicate the best way to contact you below:

Email / telephone: _____

ALCOHOL If you score 0 to the 1st question, you do not need to score questions 2 and 3.

Score	0	1	2	3	4	Enter Score
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	
2. 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 to 9	10 or More	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or Almost daily	

PLEASE NOTE, THAT IF YOU SCORE 5 AND OVER, YOU MAY BE INVITED TO MAKE AN APPOINTMENT WITH ONE OF THE NURSES FOR ADVICE

SMOKING STATUS

Do you smoke? Never ( )
Ex smoker ( ) How many a day? _____ When did you stop? _____
Yes* ( )

*How much do you smoke a day? Cigarettes / Cigars ( ) per day
Tobacco ( ) oz per week

IF YOU WOULD LIKE HELP TO STOP SMOKING, PLEASE ASK AT THE RECEPTION

LIFESTYLE **Blood Pressure** …… **Please use the quiet room**

Weight: _____ Height: _____

How much exercise do you do? light / moderate / heavy / other

What and how often? _____

Do you have a special diet? Yes / No Details: _____

MEDICAL HISTORY

Do you suffer from any of the following (please circle each condition that applies):

Epilepsy	Hay fever	Angina	Diabetes	Eczema
Heart Attack	Asthma	High B/P	Stroke	Cancer
Emphysema	Lung Problems	Bypass Surgery	Kidney Disease	
Learning Disability	Mental Health (depression / Alzheimer's disease / etc)			
Thyroid Problems:	Yes / No	Hyper-active (over) / Hypo-active (under)		

Please list any other serious or long term illnesses, operations or disabilities (with approximate dates):

_____

_____

_____

Are you on any medication / tablets, including the contraceptive pill?

Please list, including dose and frequency: _____

_____

Do you have an allergy to any medication? Yes / No

Please list: _____

_____

When was your last: Tetanus booster? _____

Polio Booster? _____

Contd. overleaf

FAMILY HISTORY (parents / brothers / sisters)

Is there any family history of the conditions mentioned on the previous sheet? Yes / No

Who:	Condition:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOR WOMEN ONLY

When was your last cervical smear done? _____

Where was it done? _____

Result? _____

Have you ever had any abnormal results? Yes / No

When? _____

Have you had a Hysterectomy? Yes / No When? _____

Have you had a Mammogram? Yes / No When? _____

Result? _____

Have you had children? Yes / No

Name: _____ DOB / Age: _____

_____ _____

_____ _____

Contd. overleaf

Ethnic Origin

Please tick the box which best describes your ethnic origin.

White

( ) British
( ) Irish
( ) Any other White background

Asian or Asian British

( ) Indian
( ) Pakistani
( ) Bangladesh
( ) Any other Asian background

Mixed

( ) White and Black Caribbean
( ) White and Black African
( ) White and Asian
( ) Any other Mixed background

Black or Black British

( ) Caribbean
( ) African
( ) Any other Black background

Other Ethnic Groups

( ) Chinese
( ) Any other Ethnic group

Prefer not to state

( )

LANGUAGE

Main spoken language? _____

UNDER 16s ONLY

Please confirm who has parental responsibility for this child:

Name	Relationship to child	Contact Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL PATIENTS

I declare that all the information I have given is correct to the best of my knowledge.

SIGNATURE: _____ DATE: _____

Where did you hear about the surgery? _____

THANK YOU FOR YOUR HELP

Dr A R Ferris, Dr C Dain, Dr S Trevor, Dr B Small, Dr S Ramanathan, Dr A Yeboah, Dr P Ng