

TOWER HOUSE SURGERY HEALTH QUESTIONNAIRE

NAME..... DATE OF BIRTH.....

ADDRESS.....

TEL NUMBER.....OCCUPATION.....

EDUCATION –TYPE AND NAME OF ESTABLISHMENT ATTENDING /PRE-SCHOOL/NURSERY/PRIMARY/SECONDARY/COLLEGE/UNIVERSITY

SMOKING Are you a current smoker?..... If yes how many do you smoke each day?.....
If you are a non smoker – Have you ever smoked?..... What date did you stop?.....

ALCOHOL Number of units per week
1unit =half a pint of beer, lager or cider/a pub measure of spirits/sherry/glass of wine

DIET What type of diet do you have (low fat, low salt etc)
Are you a vegetarian?.....

EXERCISE Which of the following applies to you?
Level 1 - 1-4 occasions of moderate/vigorous activities in 4 weeks
Level 2 – 5-11 occasions of moderate/vigorous activities in 4 weeks.....
Level 3 – 12 + occasions of moderate/vigorous activities in 4 weeks.....
Exercise physically impossible.....No exercise.....

PERSONAL MEDICAL HISTORY –indicate if you have or have had the following;

	Yes/No		Yes/No
High Blood Pressure		Asthma	
Stroke		Diabetes	
Epilepsy		Hysterectomy *	
Angina		Mental Illness/Depression*	
Heart Attack			
Operations*		Cancer *	
* Please give details			

FAMILY HISTORY <i>Parents,brothers,sisters,children</i>	NO	YES	IF YES WHICH FAMILY MEMBER
High Blood Pressure			
Stroke			
Heart Attack –less than 60 years			
Heart Attack- more than 60 years			
Diabetes			
Asthma			
Cancer			
Mental Illness			
Epilepsy			

MEDICATION (newly registered patients) Please list any prescribed medication you take including the contraceptive pill.

.....
Please list any over the counter medication you take(**All Patients**)

.....
Have you ever misused drugs or solvents?.....
Are you allergic to anything, particularly medication? – if so please give details.....

CARER-are you a Carer?..... Do you have a Carer?.....
Would you like to give us the details of your carer/next of kin so that we can contact them in an emergency?.....

IMMUNISATIONS-Have you had any of the following? Give approximate dates

	YES	NO	DATE		YES	NO	DATE
Full Childhood Course				TYPHOID			
MMR				HEPATITIS A			
MENINGITIS C				POLIO Booster as teenager			
HIB				POLIO Booster as Adult			
Rubella(German Measles)				HEPATITIS B			
BCG				JAPANESE ENCEPH			
PNEUMOCOCCAL				RABIES			
TETANUS				YELLOW FEVER			
DIPHTHERIA				MENINGITIS ACWY			

WOMEN ONLY

CERVICAL SMEAR Have you had a cervical smear? No/Yes.....
 Approx Date..... Location.....
 Result.....

BREAST SCREENING Have you ever had breast screening? No/Yes.....
 Approx Date..... Location.....
 Result.....

CONTRACEPTION What, if any, form of contraception do you use?.....
 If an IUCD (coil) Date fitted.....

BIRTHS

Dates	Complications of Pregnancy	Problems of Delivery	Birth Weight	Sex of child

MISCARRIAGES

Dates	How Many Months	Womb Scraped

Have you any medical problems at the moment?

.....

Have you any special needs?

.....

Have you any problems that it might help the doctor to know regarding your personal life, your childhood, your education, your family, your home life, or your accommodation?

Signed by patient..... Date completed.....

Surgery use only –EXAMINATION

B/P WEIGHT..... HEIGHT.....

URINE.....SMOKERS (CESSATION ADVICE GIVEN)YES/NO

DATE..... Signed by clinician.....