MOUNT ROAD SURGERY
HEALTH QUESTIONAIRE FOR NEW PATIENTS
PLEASE ANSWER ALL QUESTIONS FULLY (2 PAGES)

SURNAME: **FIRST NAME:**
DOB:
PREVIOUS GP/SURGERY:

HEALTH HISTORY: please list any important diseases/illnesses/accidents/operations/ diagnosed medical problems (with the year)

CURRENT HEALTH: is there something you need to discuss with the doctor? Please give brief details below

HIV Tests: Have you ever had one YES/NO Would you like to discuss the need for one YES/NO

FAMILY HISTORY: is there a history in your close family of (please circle) YES/NO

DIABETES YES/NO relation(s)_____
HEART DISEASE YES/NO relation(s)_____
STROKE YES/NO relation(s)_____
HIGH BLOOD PRESSURE YES/NO relation(s)

MARITAL STATUS (please **circle** one): Married./ Single/ Single parent/ Cohabiting/

Divorced/ Separated/ Widow/Widower. How many children do you have?

Who do you live with? Live alone with partner parents friends other?

ALLERGIES: are you allergic to anything e.g. tablets or medicines?

Yes No what: _____

MEDICINES: write here any tablets you take or bring a list of medicines from your last GP

Eg are you using (please **circle)**	Contraception	YES/ NO
	Inhalers	YES/ NO
	Medication from the chemist	YES/ NO
	No medicines at all	YES/ NO

EMPLOYMENT: (please **circle** one)
Are you: Employed Unemployed Student Housewife On the sick

If employed what is your job:

Smoking history:	**Please tick**
Never smoked	
Smoker How many?	
Ex-smoker. When Stopped? How many smoked?	

ALCOHOL HISTORY:

QUESTION	SCORE					TOTAL SCORE
	0	1	2	3	4	
How often do you drink alcohol?	Never	Monthly Or less	2-4 times a month	2-3 times a week	4 times a week	
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+	
How often do you have 6 or More standard drinks on one Occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or or almost daily	

A score of 5+ indicates hazardous or harmful drinking.

EXERCISE: Any exercise done for more than 20 minutes at a time counts eg walking, dancing, cycling, swimming, aerobics, football etc. Please circle one description which fits you best.

I exercise for 20 minutes once per week
I exercise for 20 minutes twice per week
I exercise for 20 minutes three times per week
I do not take any exercise

DIET: please circle one option that is closest to your diet:

I have chips or fried food most days
I have chips or fried food three or four times a week
I have chips or fried food once or twice a week
I eat a low fat diet
How many portions of fruit or vegetables do you usually eat a day (on average) _____

FOR FEMALES :
When was your last smear? 200___ was it normal YES/NO
Number of pregnancies: (children? miscarriages ? terminations?)

Do you use **contraception/ birth control**?
Please **circle.** Condoms/ coil/ pill/ implant/ injection/ sterilised/ hysterectomy/ trying to conceive/ other/ none.

ETHNICITY: (please circle)

WHITE:	**MIXED RACE:**	**ASIAN OR BLACK BRITISH:**	**OTHER:**
White British	White/Caribbean	Pakistani	Chinese
White Irish	White/African	Bangladeshi	Japanese
White Scottish	White/Asian	Indian	Middle Eastern
White Welsh	Other Mixed	African	Other
Other White	Indian/British	Caribbean	
		Other Black	

FOR DOCTOR/NURSE: Hgt ____ Wgt ____ BP _____ Urine: protein _____
EMIS Number: sugar _____
DATE:

(18.02.11)