Brookfield Park Surgery Health Questionnaire

Name: DOB:

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……

Are you a carer? ☐ Yes ☐ No

Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

For patients aged 75 or over: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐ No

In general, do you have any health problems that require you to stay at home? ☐ Yes ☐ No

Do you regularly use a stick, walker or wheelchair to get about? ☐ Yes ☐ No

In case of need, can you count on someone close to you? ☐ Yes ☐ No

Do you need someone to help you on a regular basis? ☐ Yes ☐ No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Immunsation	**Year**	**Immunisation**	**Year**
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	**What was the problem or upset?**

List of current medication ……

Name of medication	**Dosage**

Lifestyle ……

Height:	Weight:
Blood Pressure:	Waist Circumference: cm

Occupation:

Full Time/Part Time/Unemployed/Housewife-Husband/Retired/Stident (Please Circle)

Marital Status:……

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No

If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐Pipe

Are you an ex-smoker? ☐ Yes ☐ No

When did you give up?

How many cigarettes/ Cigars do you smoke daily ☐<1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like help to quit smoking? ☐ Yes ☐ No

Lifestyle alcohol ……

Do you drink alcohol: ☐ Yes ☐ No If yes, please answer the following questions:

How many units per week (please see the unit chart on the wall in reception): Units/week

How often do you have a drink that contains alcohol?

☐Never (0) ☐Monthly or less (1) ☐2-4 times per month (2)

☐2-3 times per week (3) ☐4+ times per week(4)

How many standard alcoholic drinks do you have on a typical day when you are drinking?

☐ 1-2(0) ☐ 3-4(1)☐ 5-6(2)☐ 7-9 (3) ☐ 10+(4)

How often do you have 6 or more standard drinks on one occasion?

☐ Never (0) ☐ Less than monthly (1) ☐ Monthly (2)

☐ Weekly (3) ☐ Daily or almost daily(4) **TOTAL SCORE =**

Lifestyle exercise ……

What exercise do you do?

Heavy/Moderate/Light/No Exercise (please circle)

Lifestyle Sexual Health …..

We routinely offer all new patients over the age of 16 a HIV Test, would you like this to be done?

We offer all new patients aged between 18 – 25 a free Chlamydia Test, would you like to have this done?

Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No

If yes, how many?

Which method of contraception (if any) are you using at present?

Have you had a cervical smear test? ☐ Yes ☐ No

If yes, what was the result? (if known)

Date (if known)

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Other (please state):

☐ Decline to state

Next of kin ……

Name:

Tel. contact number:

Relationship:

Where you have provided information on how to contact you, can you confirm you are happy for Brookfield Park Surgery to contact you by the following:

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

Signature ……

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐