

# HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ (Dr, Rev, Mr, Mrs, Miss, Ms)

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Tel No: \_\_\_\_\_

Present Occupation: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Are you a Carer?  Main carer for someone else?

Who for?

**Smoking**<sup>1</sup>

(Please tick appropriate box) Never smoked

Stopped smoking  date

Smokes

**Alcohol**<sup>2</sup>

How many units per week?  Units

(Unit = 1/2 pint of beer, one measure of spirits or one glass of wine)

**Medication**<sup>3</sup>

Allergic Reaction to Medication / Previous Vaccine?  Yes  No

If yes, please give details ie type of reaction and date \_\_\_\_\_

Current Medication<sup>4</sup> - Please take any medication with you. (including oral contraception) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Previous Medical History/Current Medical Problem**<sup>5</sup>

Serious illnesses \_\_\_\_\_

\_\_\_\_\_

Diabetes or Raised Blood Pressure in Pregnancy? \_\_\_\_\_

**Operations**<sup>6</sup> \_\_\_\_\_

Currently attending Out Patient Dept \_\_\_\_\_

\_\_\_\_\_

**ACTION**

(Surgery use only)

Advice <sup>1</sup>

Read Codes a  137I

On b  137L

Computer c  137R

Advice <sup>2</sup>

Read Code on comp

Teetotal a  136I

Within recomm. Limits b  136L

Above recomm. Limits c  136K

Pt records <sup>3</sup>

On Computer <sup>3</sup>

Dealt with by doctor <sup>4</sup>

On Computer <sup>4</sup>

Referred to Dr <sup>5</sup>

Asthma   
Hypertension   
Diabetes

On Computer <sup>5</sup>

Referred to Dr <sup>6</sup>

GP to re-refer if necessary

OPD notified of change of address

**Family History:**<sup>7</sup> Have your parents or any of your brothers or sisters developed any of the following

Before the age of 55	
Stroke	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>
Angina	<input type="checkbox"/>

At any age	
Bowel Cancer / Polyps	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>

**Contraception** <sup>8</sup> \_\_\_\_\_

**Tell us your approximate:** Height   
Weight

**TO BE COMPLETED BY ALL FEMALES OVER 20 YEARS**

To generate the follow up of your cervical smear we require details of your last smear

When did you last have a smear test?  /  /  Smear Result <sup>9</sup>  
Normal   
Other

Was this smear taken by :  
Your Previous GP  In Hospital  Other

Please give details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**FOR SURGERY USE ONLY**

**BP**                      **SRH**                      **Diet:**  
**Exercise:** Nil  Light  Moderate  Heavy

**ACTION**

(Surgery use only)

Referred to GP <sup>7</sup>

On computer <sup>7</sup>

GPC <sup>8</sup>

Follow up arranged (IUD etc) <sup>8</sup>

BMI on computer

PT1 <sup>9</sup>

On yellow sheet

Hypertension FU Required

“What Should I Do” Booklet Z1011

Registration Exam GPC