

GENERAL HEALTH QUESTIONNAIRE

Thank you for applying to join Shakespeare Surgery. We are interested in your general health and up to date information will help us decide what initial assessment you need. If you could please fill out the following questionnaire accurately and fully. If you are unsure of an answer leave that bit blank.

Title First Name(s).....Surname.....

Date of Birth Marital Status NHS Number

Address

..... Post Code Telephone Number

The Dept of Health asks us to gather ethnic group data at registration. Please can you indicate an answer by ticking one response

- | | |
|--------------------------------------|---|
| British .9i0 | White and Asian .9i5 |
| Irish .9i1 | Other Mixed Background .9i6 |
| Other white British .9i2 | Indian or British Indian .9i7 |
| White and Black Caribbean .9i3 | Pakistani or British Pakistani .9i8 |
| White and Black African .9i4 | Bangladeshi or British Bangladeshi .9i9 |
| Caribbean .9iB | Other Asian Background .9iA |
| African .9iC | Other Black Background .9iD |
| Asylum Seeker .13ZN | Chinese .9iE |
| Other (Please state what)9iF | |
| Not Stated .9iG | Decline to answer .9SI |

Have you had/still have any of the following ?

- | | | | | | |
|----------------|--------|------------------|--------|-------------------|--------|
| Angina | YES/NO | Diabetes | YES/NO | Cancer | YES/NO |
| Blood Pressure | YES/NO | Depression | YES/NO | Bronchitis/Asthma | YES/NO |
| Epilepsy | YES/NO | Stroke | YES/NO | Heart Attack | YES/NO |
| Arthritis | YES/NO | Thyroid Problem | YES/NO | Tuberculosis | YES/NO |
| Stomach Ulcer | YES/NO | Other Illnesses? | | | |

Any Operations?

Can you list the medication that the Dr is giving you that you are taking at present?

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Are you taking any medication other than that given by the Dr?

..... Any Medications Allergic To.....

Are you under the care of a Hospital at present YES/NO

Details Specialist Name	Hospital	Diagnosis
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If known current

HEIGHT WEIGHT Blood Pressure

Do you smoke YES/NO If yes how much/many per day

Did you used to smoke YES/NO If yes how much/when did you stop

Do you drink alcohol?YES/NO If yes what do you drink and how many per week.....

.....

Is there any family history of any Health problems (e.g. lung/heart problems/Blood pressure etc)

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Are you working YES/NO If yes what is your job?

Has your health affected your ability to work? YES/NO If yes in what way.....

.....

Are there any other general problems affecting you that you think we should know about?

.....

.....

Women Only

Are you currently pregnant? YES/NO Have you been Pregnant? YES/NO

Any Problems with pregnancy (miscarriages, difficult deliveries etc) YES/NO

Details

Are you using any birth control YES/NO? Details

When was your last smear?

Children Only

Are you up to date with all immunisations YES/NO

If no which have you not had?

Where did you hear about Shakespeare Surgery from? (please tick all that apply)

Recommendation from family/friend? Internet? Primary Care Trust?

Local Hospital? Newspaper Advert? Leaflet? Other surgery in building?

Elsewhere? (please specify)

Next of Kin:Telephone Number.....

Thank you for helping in this health review. Please return the form to reception for processing