Health Questionnaire

Personal Details Date Completed _____ Nationality _____

Title: _____ Full Name: _____

Date of Birth: _____ Any previous names? _____

Address: _____

_____Post code: _____

Telephone _____ Mobile _____

If not British origin - how long have you been in this country? _____

Marital Status (please delete) - Single / Married / Divorced / Separated / Civil Partnership / Widowed

Next of Kin: Name: _____ Relationship to you: _____

Contact Number: _____

Do you have someone who provides you with help and support (friend / partner / family member)? YES / NO

(If YES please ask Reception or Nurse for registration card)

CHILDHOOD ILLNESSES

Please tick if had, and approximate age if possible:-

Mumps	☐	Age _____	Measles	☐	Age _____
Chickenpox	☐	Age _____	German Measles	☐	Age _____
Scarlet Fever	☐	Age _____	Rheumatic Fever	☐	Age _____
Whooping Cough	☐	Age _____	Childhood Eczema	☐	Age _____
Childhood Asthma	☐	Age _____	Diphtheria	☐	Age _____

ALLERGIES

Are you allergic or sensitive to any medications, food, animals etc.?

Health Questionnaire

ILLNESSES, ACCIDENTS OR OPERATIONS
Please list all serious illnesses, accidents, hospital admissions or operations with dates and hospital attended:

CURRENT MEDICATIONS AND WHAT THEY ARE PRESCRIBED FOR:

BLOOD

Do you know your blood group? _____

Have you ever been a blood donor? _____

Have you ever received a blood transfusion? (details) _____

LIFESTYLE

Are you a smoker? (details) _____

How much alcohol do you drink in an average week? _____

Do you take any regular exercise? (details) _____

WEIGHT

Do you know your weight? _____

Have you lost or gained weight recently? _____

Health Questionnaire

HEIGHT

What is your height? _____

OCCUPATION

What is your occupation? _____

What jobs have you had in the past? _____

FAMILY HISTORY

Are your parents still alive and in good health? _____

Mother _____ Father _____

Brothers and sisters and their ages?

Do you or any close relations have any of the following? (please give details)

Diabetes	YES / NO	_____
High blood pressure	YES / NO	_____
Heart Attack	YES / NO	_____
Stroke	YES / NO	_____
Epilepsy or fits	YES / NO	_____
Asthma	YES / NO	_____
Skin Disease	YES / NO	_____
Anxiety / Depression	YES / NO	_____
Cancer	YES / NO	_____
Kidney Disease	YES / NO	_____
Other	YES / NO	_____

Health Questionnaire

WOMEN ONLY

Contraception

Do you use any contraception? YES / NO. If Yes, what do you use? _____

If you are taking the pill, how long have you been taking it for? _____

Do you get any side effects? _____

Cervical Smears

Have you had a cervical (cancer) smear? YES / NO

If yes, where was it performed? (Please circle answer)

Previous surgery / Private Clinic / Family Planning Clinic / Other

(Please give name/address if possible): _____

If yes, approximately what date? _____

Children

Please list all the children you have had:

Name _____ Birth weight _____ D.O.B. _____

Any problems with pregnancy or birth _____

Name _____ Birth weight _____ D.O.B. _____

Any problems with pregnancy or birth _____

Name _____ Birth weight _____ D.O.B. _____

Any problems with pregnancy or birth _____

Name _____ Birth weight _____ D.O.B. _____

Any problems with pregnancy or birth _____

Have you ever had a miscarriage? (please give details) _____

_____