# Central Surgery Health Questionnaire

Please complete this questionnaire as fully as possible. The information that you provide will help the clinical staff make an initial assessment of your health, which will help in your future treatment.

| **Name** | **Date of Birth** |
|---|---|
| **Address** | |
| **Home Phone Number** | |
| **Mobile Phone Number:** | |

Please tick one of the following boxes to confirm your preferred contact number**:**

Home Phone Number ☐ Mobile Phone Number ☐

Please tick one of the following boxes to confirm your preferred method of contact:

SMS ☐ Email ☐ Letter ☐

## SMS Text Messaging Service

If you wish to consent to the SMS texting service, please sign the declaration below:

**I CONSENT to the practice contacting me by text message for the purpose of health information, appointment reminders and test results.**

I acknowledge that it is my responsibility to inform Central Surgery of any change in my mobile number or if the number is no longer in my possession.

Sign …….. Date ……

If you are happy for us to contact you periodically by email please fill in your email address

| **Email:** |
|---|

**Nominated Pharmacy – Electronic Prescription Service (EPS)**

This service allows us to send your prescriptions directly to your chosen pharmacy. This paper-free prescription service means that you do not have to come into the surgery to collect your prescription.

| **Please fill in your nominated Pharmacy:** |
|---|

**If you have any information or communication needs please tick here ☐**

**Ethnic origin**

| | | | | | |
|---|---|---|---|---|---|
| White British | ☐ | White Irish | ☐ | Other mixed white | ☐ |
| Asian | ☐ | British Asian | ☐ | Black British | ☐ |
| Black African | ☐ | Other | ☐ | | |

If other, please give details

| | | | |
|---|---|---|---|
| **Height** | | **Weight** | |

**Smoking Status**

Do you currently smoke? Yes ☐ If yes, how many per day?
No ☐ If no, have you ever smoked? Yes ☐ No ☐

**Exercise**

Do you exercise? Yes ☐ No ☐

If yes, please provide some details.

**Are you housebound**? Yes ☐ No ☐

Do you have anyone that looks after you or your daily needs? Yes ☐ No ☐

**If yes**, would you like them to deal with your health affairs* here? Yes ☐ No ☐

**Confidentiality is very important - this means we can only discuss test results and prescription details directly with the patient.* ***If you want someone else to enquire for test results and prescription details on your behalf, you need to complete an authorisation form****. This can be obtained from Reception.*

**Do you care for someone else?** Yes ☐ No ☐

We are dedicated to offering you as much help & support as needed. Please register as a carer. We can offer: flexible appointments, flu vaccinations, annual health check and referral to Carers in Hertfordshire.

To register as a Carer please either collect a Carers Welcome Pack from Reception or download from our website www.centralsurgerysawbo.nhs.uk.

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**Family History**

Is there any history of the following in your family?

| **Condition** | **Yes** | **No** | Which family member? ***(Paternal/Father's family or Maternal/Mother's family)*** | Diagnosed before or after age sixty? **Before** | **After** |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Diabetes | | | | | |
| Stroke/TIA Mini stroke | | | | | |
| Heart problems | | | | | |
| Cancer | | | | | |

**If yes** to cancer, please provide some details

| |
|---|
| |

**Allergies**

Please list any allergies that you are aware of (e.g. allergy to medication or foodstuff)

| |
|---|
| |

**Current Medication**

Please list any current prescription medication you are taking. (If possible, attach a copy of your last repeat prescription from your previous surgery)

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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**Medical History**

Have you ever been diagnosed with any of the following?

| Condition | Yes | No | Details |
|---|---|---|---|
| Asthma | | | |
| CKD | | | |
| COPD | | | |
| Diabetes – Type 1 | | | |
| Diabetes – Type 2 | | | |
| Emphysema (Chronic Lung disease) | | | |
| Epilepsy | | | |
| Heart problems - Heart attack, Angina, AF | | | |
| Hypertension | | | |
| Over active Thyroid | | | |
| Under active Thyroid | | | |
| Stroke, TIA or mini-stroke | | | |
| Mental Health Problems | | | |
| Cancer | | | |

**Contraception** (female patients only)

Are you currently using any form of contraception? Yes ☐ No ☐

**If yes**, which form of contraception do you use?

| | | | | | |
|---|---|---|---|---|---|
| Oral contraceptive pill | ☐ | IUCD / Coil | ☐ | Contraceptive injection | ☐ |
| Condoms | ☐ | Cap | ☐ | Implant | ☐ |

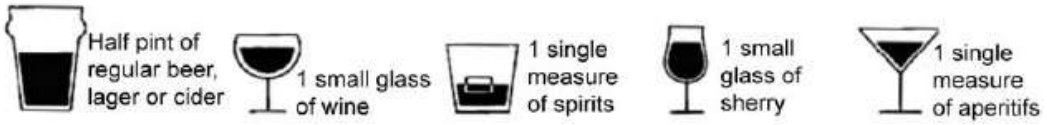
**For children aged 0 – 16**

Please complete the following with vaccination dates

| When to immunise | Diseases protected against | Vaccine given | Date given |
|---|---|---|---|
| Eight weeks old | Diphtheria, Tetanus, Pertussis (whooping cough), Polio and Haemophilus influenzae type b (Hib), Pneumococcal (13 serotypes), Meningococcal group B (MenB), Rotavirus gastroenteritis | DTaP/IPV/Hib/HBV + Pneumococcal conjugate vaccination (PCV) + Men B + Rotavirus | |
| Twelve weeks old | Diphtheria, Tetanus, Pertussis, Polio and Hib, Rotavirus | DTaP/IPV/Hib/HBV + Rotavirus | |
| Sixteen weeks old | Diphtheria, Tetanus, Pertussis, Polio and Hib, Pneumococcal (13 serotypes), MenB | DTaP/IPV/Hib/HBV+ Pneumococcal conjugate vaccination (PCV) + Men B | |
| One year old | Hib and MenC, Pneumococcal, Measles, Mumps and Rubella (German measles), MenB | Hib/MenC + Pneumococcal conjugate vaccination (PCV) + MMR + Men B booster | |
| Three years four months old or soon after | Diphtheria, Tetanus, Pertussis and Polio, Measles, Mumps and Rubella | DTaP/IPV + MMR | |

**Name: ..... DOB .....**

## This is one unit of alcohol…




## …and each of these is more than one unit

## AUDIT – C

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Date Completed: .....

# Children Aged 5 & Under Form

As you are now registering with our practice we would be grateful if you would complete this form which will be passed to the Health Visiting Service.

**Children's details**

| Surname of all children (including those over 5) | Forenames | Date of Birth | Male (M) /Female (F) | NHS Number | Ethnic Origin |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Parent's details**

| Surname | Forenames | Date of Birth | Relationship to child | NHS Number | Ethnic Origin |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Present Address:**

**……**

**…… Postcode …….**

**Telephone number: …… Mobile: ……..**

**Previous Address:**

**……**

**…… Postcode …….**

**Thank you for completing this form.**

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