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:

When returning this completed form to us you must attach a copy of your last repeat prescriptions from your previous surgery

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.

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)

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	☐

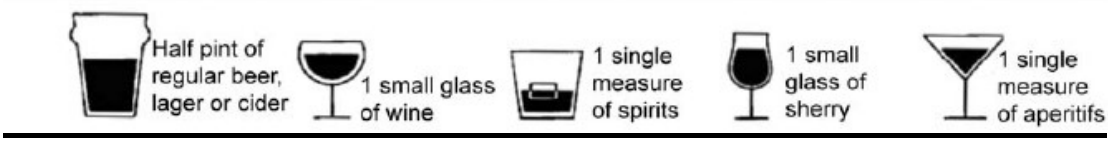
For children aged 0 – 16

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.