

Confidential Health Questionnaire

Please hand this form back to the receptionist

www.StMarysHealth.co.uk
www.facebook.com/SMTHSurgerySurname Forename DOB Male Female Are you a student? Tick if yes Southampton Address Mobile I consent to receiving reminders & information from the surgery by SMS text: Yes No Email Address Only put email if you are happy to receive information by email. If you do not please leave blank.Next of Kin
Name, address and
relation to youName: Relation to you:
Address:
Phone number: Are you a carer? YES NO ...Or do you have a carer look after you? YES NO Carers Name and contact phone number

If you would like information on receiving support for carers please ask at reception for a carer information pack

Please include a list of household members, this includes family

Name	DOB	Relation to you
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please add any more on the back

School/College if under 18 years of age Social Worker if you have one Are you under any other health agencies? Please write **Do you have any ALLERGIES TO MEDICATION? Please list****Tick ANY box or boxes that describe close family (parent/brother/sister) history of:**

Stroke (CVA)	<input type="checkbox"/>
High Blood Pressure (Hypertension)	<input type="checkbox"/>
Angina/Coronary Heart Disease/Heart Attack <60	<input type="checkbox"/>
Angina/Coronary Heart Disease/Heart Attack >60	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Cancer	<input type="checkbox"/>

Smoking

If you are a SMOKER how many cigarettes do you smoke a day?	<input type="text"/>
If you are an EX-SMOKER what year did you stop smoking?	<input type="text"/>
I have NEVER SMOKED cigarettes or tobacco	<input type="checkbox"/>
I use an ELECTRONIC CIGARETTE	<input type="checkbox"/>

PLEASE TURN OVER

Alcohol	0	1	2	3	4	Score
How often do you have a drink that contains alcohol? (circle the answer that best describes your drinking habit)	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or most days	

Total Score =

Please tick one:

Ethnicity		Main Spoken Language	Level of English
White	British	English	Good English
	Irish	Arabic	Poor English
	Mixed	Cantonese	Interpreter Needed
	Other	French	
Black	African	Gurjerati	
	British	Hindu	
	Caribbean	Mandarin	
	Mixed	Polish	
	Other	Portuguese	
Asian	Bangladeshi / British Bangladeshi	Punjabi	
	Chinese	Russian	
	Indian / British Indian	Somali	
	Pakistani / British Pakistani	Swahili	
	Other	Urdu	
Mixed	White & Asian	Other – Please write below	
	White & Black African		
	White & Black Asian		
	White & Black Caribbean		
Other	Arab		
	None of the Above		
	Don't Want To Say		

Religion	Marital Status
Atheist	Single
Buddhist	Married
Christian	Separated
Church of England	Divorced
Hindu	Widowed
Islam	Same Sex Couple
Jehovah's Witness	Engaged
Jewish	Cohabiting
Roman Catholic	Other
Sikh	
Other – please write	
Don't Want To Say	

PLEASE CONTINUE ON NEXT PAGE

Do you consider yourself to be:

An Asylum Seeker: YES NO

A Refugee: YES NO

If you are from overseas and are under 18 years of age do you have your vaccination history?

YES NO *If yes please bring this in so we can make a copy for your records*

Do you suffer from asthma? YES NO

If yes please inform a receptionist who will give you a respiratory questionnaire to complete

If you are currently taking any **MEDICATION** regularly or have any long term health problems, please could you make an appointment to see the doctor.

New Patients – Please now make an appointment with the nurse for a health check.