Pine Street Medical Practice Health Questionnaire

PT Number: …………………………………………

All questions must be answered to enable this practice to register you.

Name……………………………………………… D.O.B……………………………………..
Email address………………………………………………………………………………………

Are you happy for us to contact you via email Yes/No

Do you smoke Yes/No (please circle)
If Yes
How many cigarettes per day……………………………………………
How many cigars per day…………………………………………………..
If roll ups how many ounces per day………………………………..
If No
Have you ever smoked? **If yes: when did you give up?......................**
Cigarettes per day……………………………………………………………
Cigars per day…………………………………………………………………..
Roll ups ounces per day……………………………………………………..

Do you drink Alcohol?
Please circle the answer that is correct for you

1) How often do you have a drink containing alcohol

Never (0) Monthly or Less (1) 2-4 times per month (2) 2-3 times per week (3)

4 or more per week (4) **Score =**

2) How many drinks containing alcohol do you have a typical day

1 or 2 (0) 3-4 (1) 5-6 (2) 7-9 (3) 10 + (4) **Score =**

3) How often do you have 6 or more drinks on one occasion?

Never (0) monthly or less (1) 2-4 per month (2) 2-3 per week (3) 4 or more per week (4)

Score = **Total Score =**

Do you exercise Yes/No (please circle)

If yes what exercise do you do………………………………………………………

<u>Do you or have you had any of the following (</u><u>please circle)</u>

Heart Attack, Stoke, High Blood Pressure, Angina, Diabetes, Epilepsy, TB, Glaucoma, Thalassaemia, Sickle Cell or Asthma
Other ………..

<u>Have any of your family had any of the following</u> <u>(please circle and state who)</u>

Heart Attack, Stoke, High Blood Pressure, Angina, Diabetes, Epilepsy, TB, Glaucoma, Thalassaemia, Sickle Cell or Asthma

Are you allergic to anything…………………………………………………………………..

Are you on any current medication Yes/No (please circle)

If yes please state:……………………………………………………………………………….

Are you taking/using contraception Yes/No (please circle)

If yes please state:……………………………………………………………………………….

<u>Females Only</u>

When was you last Cervical Smear test……………………………………………….

Date and Result……………………………………………………………………………………….

Have you had any abnormal Cervical Smear Yes/No (please circle)

If yes when……………………………………………………………………………………………….

Have you had a Hysterectomy Yes/No (please circle)

If yes which hospital and when……………………………………………………………..

<u>Adults and Children</u> are you up to date with your immunisations?

For children please attached a copy of the **Red Book** (our receptionist will copy this for you)

What school does your child attend…………………………………………………….

<u>Carers</u>

Are you a carer Yes /No

If yes who for……………………………………………………………………………………………..

If you have a carer please see a member of our reception team for a carers form. This must be completed by you; otherwise we will not be able to liaise with your carers.

Do you consent for us to liaise with your carer Yes/No

Who is your next of Kin:

Name…………………………………………..Address…………………………………
……………………………………………………………………Phone Number…………………………………………

Do you give your permission to discuss your medical history with your next of kin Yes/No

You will automatically be sent a text reminder for any appointment you may have. Please sign here if you wish to opt out……………………………………

Information of Ethnic Recording

In line with other healthcare providers and all other statutory service such as local authorities etc, now collect information about ethnic group of patients. This information will help us learn more about patients' needs and then allow to plan services to meet health needs of the entire community and ensure that everyone has access to healthcare. All information we receive will be used and treated strictest confidence. **Ethnic Group please circle which one applies to you.**

White
British
Irish
Any other White background. Please state…………………………………………………

Mixed
White & Black Caribbean
White & Black African
White & Asian
Any other mixed background. Please state…………………………………………………..

Asian or Asian British
Indian
Pakistani
Bangladeshi
Any other Asian background. Please state………………………………………………….

Black or Black British
Caribbean
African

Any other Black background. Please state…………………………………………………………

<u>Other Ethnic group</u>
Chinese
Any other ethnic background. Please state……………………………………………………

What is you first language………………………………………………………………………………..

Do you speak English (please circle) **Yes**   **No**   **Some**

Do you need an Interpreter? (Please circle)

Yes   **(**State which language) **……………………………………………..**
No

Patient Signature   Proof of address/ID   Staff Signature