



☎01423 503035
☎01423 558100 (Jennyfield Health Centre)

Fax 01423 562665
www.stlukesdoctors.co.uk

Confidential Health Questionnaire

Please help the doctor by completing this form as we will not receive your Medical Records for some time.

Title Mr/Mrs/Miss/Ms/Dr/Rev/Other **First Name(s)** **Surname**
Date of Birth **Occupation**
Address **Town/Village** **Postcode**
Telephone Number **Home** **Work** **Mobile**

Ethnic Origin

White British White Irish Other Mixed
White Other White & Black Caribbean Indian/British
White & Black African White & Asian Bangladeshi/British
Pakistani/British Other Asian Caribbean
African Other Black Chinese

Other (please specify)

Language

Please tell us what your first language is

Please list any serious illness, accidents or operations you have had.

Do you have a carer Yes No

Are you a carer Yes No

At times we may need to contact you at home. Please sign below if you wish to give us consent to:

1. Leave messages on your answer phone
2. Inform another member of the household that the surgery has phoned

SIGNATURE:

DATE:

Smoking

Smoking seriously dangers your health

Never

Ex-Smoker (When did you stop?)

Under 10 a day

10-20 a day

Over 20 a day

Exercise

How much exercise do you take? Walking, sports etc.

Avoid Light Moderate Heavy Exercise Competitive Athlete

If you need advice about any of the following, please make an appointment to see Practice Nurse.

Well Person

Stress

Diet Exercise

Weight

Smoking

Drinking

Answer the following questions



Fast Alcohol Screening Test (FAST)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: A total of 3+ indicates hazardous or harmful drinking

Please tick below any illness you or any of your immediate family or close relations have suffered from:

Please state if family member or self.

Diabetes

Bronchitis

Asthma

High Blood Pressure

Cancer Specify

Epilepsy or Fits

Stroke

Nervous Disorders

Duodenal Gastric

Ulcer

Thyroid Disorder

Heart Disease <60

>60

Any Other condition? Yes No

(If Yes, please give details)

Do you have any allergies? Yes No

(If Yes, please give details)

Have you, within the last 10 years had any vaccinations, e.g. tetanus Yes No

(If yes, please specify and give approx date)

FEMALES ONLY

	Yes	No
Have you had a cervical smear test?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last test		
Result		
Is there any family history of breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Please give details.....		
Have you ever had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>
Date		
Result		
Please list your pregnancies and any difficulties experienced.		
Do you have any other problems you would prefer to discuss with the doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you for filling in this form
Please hand in at Reception with your registration form.**