HEALTH QUESTIONNAIRE Date:…….

Surname…… First Names(s) ……Date of Birth ….……Age…..…

Full address in Southampton ……...……

Telephone Number:…….. Occupation ……. Marital Status……

E-Mail address:……. ONLINE ACCESS (for appointments, prescriptions & care record) Y/N

For registration of Children (0-18 years)

Name/Contact details of person with parental responsibility ……

Name of Social Worker (if applicable) ……..

Are there any child protection issues? ……

ARE YOU HAPPY TO SHARE YOUR MEDICAL RECORDS WITH OTHER NHS PROVIDERS YES / NO

WOULD YOU LIKE TO JOIN OUR PATIENT PARTICIPATION GROUP YES/NO

Ethnic Group (Please Circle)

White:-	White British	Irish	Other White(please specify)…….		
Mixed:-	White&Black	Caribbean	White&Black African	White&Asian	Other Mixed
Asian/Asian British:-		Indian	Pakistani	Bangladeshi	Other Asian
Black/Black British:-		Caribbean	African	Other Black	
Chinese or Other Group:-		Chinese	Other Ethnic(please specify)…….		

Religion:…….. Language: English – YES / NO (please circle) Other Languages……..

General Medical History : Do you have any serious illnesses?(please tick below)

Coronary Heart Disease [ ] Chronic Obstructive Pulmonary Disease (COPD) [ ] Stroke [ ] Diabetes [ ]

Hypertension [ ] Asthma [ ] ***For Asthma please state year of diagnosis*** ……Cancer (State type)…….

Epilepsy [ ] Thyroid [ ] Mental Health Problems [ ] Other (please state) ……..

Family History:

Which of your immediate blood relations has suffered the following when under 65 years of age?

Heart Attack…….. Stroke…… Cancer……...

Do you have a learning disability? YES / NO (please circle) Details: ……..…….

Height: …….. **Weight:** …….

Have you had any serious illnesses or operations, X-rays or similar tests and when?

……

What medicines are you taking (including the pill for females)

…….

Have you any allergies to medicines or anything else?…….

How much alcohol do you drink in a week?……..

Do you smoke tobacco or cigarettes? Yes, Current Smoker ☐ No, Ex Smoker ☐ No, Never Smoked ☐

If Yes, how much tobacco or cigarettes do you smoke?……...

What Vaccinations have you had and when?

Diphtheria…… Polio…… Tetanus…….. Measles……

MMR……. German Measles……. Meningitis…… Whooping Cough…….

Hep A…….. Hep B……. BCG……. Yellow Fever ……. Typhoid……..

Female Patients Only – Have you any children?(give ages)…….

Have you had any miscarriages?(dates)……Have you had a termination of pregnancy?(dates)……

Have you had a hysterectomy?(date)…….. What method of contraception do you use?……..

When was your last cervical smear test?……

Health Check appointment date…… Nurse Cath Jodi Susan Lisa

GP appointment date……. Dr Dave Dr Bhatt Dr Hall Dr Day Dr Shetty Dr Silson, Locum