HILLINGDON HEALTH CENTRE PATIENT QUESTIONNAIRE

Surname:	Forenames(s):

Previous Surname:	Date of Birth:	Sex: Male/Female

Main Language Spoken:	Marital Status:
Home Telephone No:	Mobile Telephone No:
Email Address:	

Town and Country of Birth: (Just London is not acceptable)
Occupation:
Name and Telephone Number of Next of Kin:
Current Medication:
Allergies:

Ethnicity					
White British		White & Asian		Other Asian	
British Mixed		Other Mixed		Other Black	
Other White		Indian/British		Chinese	
W&B Caribbean		Pakistani/British		Irish	
W&B African		Bangladeshi/British		European	
Other					

Personal Medical History:

Asthma	Yes/No		Strokes	Yes/No
Blood Pressure	Yes/No		Glaucoma	Yes/No
Diabetes	Yes/No		Cancer	Yes/No
Angina	Yes/No		Heart Disease	Yes/No
Epilepsy	Yes/No			

Any other major illnesses, operations or disabilities:

Height:	Weight:

Do you Smoke?: Yes/No	If so, how many per day?:

Alcohol Consumption (those patients over 16 years of age)

Questions – please circle answer	Scoring System

	0	1	2	3	4	Your Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3times 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	

Exercise:
Do you undertake any regular sport or exercise on a daily or weekly basis? Yes/No
If so, what and how often?

Have you ever had a tetanus immunisation? Yes/No
If yes, when was your last booster?

For registering children please produce your "Red Book" or equivalent which lists immunisations.

Date:…………………………………………………………………….