****Please help us to look after your health by answering the following questions

**About You:**

Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title \_\_\_\_\_\_\_\_\_\_\_

Forenames \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give consent for the practice to e-mail or text non confidential material

Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Preferred mode of contact e-mail/text

E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:**

White Scottish\_\_\_ Other White British \_\_\_ White Irish \_\_\_ Other White \_\_\_

Any Mixed Background \_\_\_Indian \_\_\_ Pakistani \_\_\_ Bangladeshi \_\_\_ Chinese \_\_\_ Other South Asian \_\_\_ Caribbean \_\_\_ African \_\_\_Black Scottish/Other Black \_\_\_

Other Ethnic Background \_\_\_

**About Your Health:**

Do you have any allergies? If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your past/current illnesses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Date** | **Condition** | **Date** |
| Diabetes |  | Asthma |  |
| Heart Disorders |  | COPD |  |
| Blood Pressure – High |  | Epilepsy |  |
| Blood Pressure – Low |  |  |  |
| Kidney Problems |  | Cancer (type) |  |
| Mental Health |  | Dementia |  |
| Stroke |  | TIA |  |
| Thyroid |  | Learning Disabilities |  |
| Other  |  |  |  |
| Operations |  |  |  |

Date of Last Cervical Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**

|  |  |  |
| --- | --- | --- |
| Name of Medicine | Strength | How Often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Immunisations**

Please list any immunisations you have had to date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Family’s Health**

|  |  |  |
| --- | --- | --- |
| **Illness** | **Who in Family** | **Age Occurred** |
| Heart Disorders |  |  |
| Diabetes |  |  |
| Stroke |  |  |
| Cancer (type) |  |  |
| High/Low Blood Pressure |  |  |
| Asthma |  |  |
| Kidney Problems |  |  |
| Thyroid |  |  |
| Epilepsy |  |  |
| Dementia |  |  |
| Other |  |  |

**About Your Lifestyle:**

Smoker Yes / No Number per day \_\_\_\_\_

Ex Smoker Yes / No Number per day\_\_\_\_\_\_ Year stopped \_\_\_\_\_\_\_\_\_

Never Smoked

No of Units per week (1 Unit is half pint beer, glass of wine or single measure of spirit)

Alcohol beer / lager \_\_\_\_\_\_ wine \_\_\_\_\_\_ spirits \_\_\_\_\_\_ total \_\_\_\_\_\_

Diet Mixed / Vegetarian / Vegan / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Regular / Moderate / Little / None

Are you a carer for another person Yes/No

Do you receive care from another person Yes/No