PATIENT HEALTH FORM

We are offering all our patients a Health & Lifestyle Check with one of our Practice Nurses. This will afford you the best opportunity for continued good health, particularly in the period until we receive your medical record. However if you have any problems these should be discussed with a Doctor during a routine appointment.

Name: .... Title:..

Address: ....

Post code:.. Telephone no:..

Sex: ....

Date of Birth: ....

VERY IMPORTANT !!!
MEDICAL HISTORY-PLEASE ALSO GIVE DATE/YEAR OF START OF CONDITION

Have **you** ever suffered from:	**DATE**		**DATE**
a. Angina	Yes / No	g. Heart Attack	Yes / No
b. High blood Pressure	Yes / No	h. Stroke	Yes / No
c. Diabetes	Yes / No	i. Cancer	Yes / No
d. Asthma / COPD	Yes / No	j. Epilepsy	Yes / N
e. Mental health	Yes / No	k. Hypothyroidism	Yes / No
f. Chronic Kidney Disease	Yes / No		

Family history of :

a. Angina	Yes / No	g. Heart Attack	Yes / No
b. High blood Pressure	Yes / No	h. Stroke	Yes / No
c. Diabetes	Yes / No	i. Cancer	Yes / No
d. Asthma / COPD	Yes / No	j. Epilepsy	Yes / No
e. Mental health	Yes / No	k Hypothyroidism	Yes / No
f. Chronic Kidney Disease	Yes / No		

Please give details of any operations and/or serious illness:...

Are you a non paid carer ? **Yes/No**

Medication:

Do you regularly take Painkillers, Sleeping tabs or Tranquillisers? Yes/No

Please list current repeat medication...

....

Details of any allergies..

Do you take any illegal drugs, if yes, what and amounts?...

Females Only

Have you had a hysterectomy Yes/No **If No, date of last smear test** ....

Method of contraception (if applicable) ....

No of children & ages (if applicable) ....

Mammogram (over 50s) ....

Children under 5 ONLY

Please give details of immunisations and dates:

The above information is correct to the best of my belief. The information will be checked when your records are received from your previous surgery. If you change your address or telephone number you must advise us so that we can keep your medical file up-to-date.

If you give false information you may be put off our list.

Signature:.. **Date:** ....

HEALTH & LIFESTYLE INFORMATION

For Practice use Only

Weight .... Height........................

Overweight ☐

Obese ☐

Offered HP on exercise ☐

Offered HP on diet ☐

Exercise

Physically impossible ☐

Avoids even trivial ☐

Enjoys light ☐

Enjoys moderate ☐

Enjoys heavy ☐

Competitive athlete ☐

Alcohol

Alcohol intake within rec limits ☐

Alcohol intake above rec limits ☐

Stopped drinking alcohol ☐

Currently non drinker ☐

Teetotal ☐

Smoking

Never smoked tobacco ☐

Ex-smoker ☐

Current smoker ☐

cessation advice given ☐

Urinalysis

No abnormality ☐

Result awaited ☐

Abnormal ☐