

Health Form

(All Information given is added to Your Medical Record)

Today's Date:

Date of Birth:

Male/Female:

Town and Country of Birth:

Occupation:

(If you are a student please supply name of college, course and end date of course)

Students: 1st year 2nd year 3rd year
(Please circle)

Marital Status:

Are you Single, Married, Separated, Divorced Or Widowed?

Previous Surname:

Do you have children?

If so, please give details as follows:

Girl/Boy

Date of Birth

Health Screening

Do you smoke?
If yes, how many per day?

IF YOU ARE A SMOKER, WE STRONGLY ADVISE THAT YOU STOP.
PLEASE CONTACT SMOKERS HELPLINE WALES: 0800 1690169

Do you drink alcohol?
If yes, units per week?

What is your approx. height?
What is your weight?

THIS QUESTION IS FOR FEMALES ONLY

Have you had a Cervical Smear?

If you had a Cervical Smear Abroad, please complete a "Smear Abroad" form.

Females who are 20 years and over are advised to have a smear every 3 years.

Surname: _____

Forenames: _____

Address: _____

Post Code: _____

Contact Numbers:
(House and Mobile)

Email Address:

Do you live in a House, Flat, Bedsit or Halls of Residence?

Is it Owned or Rented?

Medication

Do you take routine medication?
(e.g. oral contraceptive pill, blood pressure tablets)

Please enclose last prescription re-order form

If yes, please give us details as follows:

<u>Drug Name</u>	<u>Dose</u>	<u>How Many Times a Day</u>
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Are you allergic to any medication that you know of?
(e.g. penicillin)

If yes, what?

Have you misused drugs?

If yes, which drug?

How often?

Medical History

Have you ever suffered from the following?

If YES. Please tick appropriate item and add the year alongside the condition.

- | | <u>Year</u> |
|--|-------------|
| <input type="checkbox"/> Heart Attack _____ | |
| <input type="checkbox"/> Angina _____ | |
| <input type="checkbox"/> Stroke _____ | |
| <input type="checkbox"/> High Blood Pressure _____ | |
| <input type="checkbox"/> Diabetes _____ | |
| <input type="checkbox"/> Emphysema/COPD _____ | |
| <input type="checkbox"/> Epilepsy _____ | |
| <input type="checkbox"/> Thyroid Disorder _____ | |
| <input type="checkbox"/> Cancer _____ | |
| <input type="checkbox"/> Asthma _____ | |
| <input type="checkbox"/> Depression _____ | |
| <input type="checkbox"/> Mental Health Problem _____ | |
| <input type="checkbox"/> Dementia _____ | |
| _____ | |
| <input type="checkbox"/> T.B.(Tuberculosis) _____ | |
| <input type="checkbox"/> Jaundice _____ | |
| <input type="checkbox"/> Skin Disease _____ | |
| <input type="checkbox"/> Stomach Ulcer _____ | |
| <input type="checkbox"/> Kidney Disease _____ | |
| <input type="checkbox"/> Hay Fever _____ | |
| <input type="checkbox"/> Malaria _____ | |

Operations:

(Specify and give approx. year e.g. hysterectomy)

Have you had any other significant illnesses?

Disabilities

Please indicate if you have any of the following conditions.

If YES. Please tick appropriate item.

- | |
|--|
| <input type="checkbox"/> Impaired Hearing/Deaf _____ |
| <input type="checkbox"/> Speech Impaired _____ |
| <input type="checkbox"/> Partially Sighted/Blind _____ |
| <input type="checkbox"/> Mobility Impaired _____ |
| <input type="checkbox"/> Learning Disabilities _____ |

Carers

Are you a Carer? _____

Who do you Care for? _____

Is this person registered here? _____

Do you have a Carer? _____

If yes, please provide the carer's name and contact number? _____

Patients may be accompanied at appointments by a carer and/or advocate and/or assistant.

Family History

Please provide us with information on the health of your family?

Parents:

	<u>Age</u>	<u>State of Health</u>
Mother _____		

Father _____		
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Brothers or Sisters:

<u>Boy/Girl</u>	<u>Age</u>	<u>State of Health</u>

Are there any family illnesses?
(e.g. heart problems, diabetes)

Have you had a 'MEN C' vaccination?

Date

Have you had a second 'MMR' vaccination?

Date

Please inform reception if you have a preferred GP. Remember that an appointment with a specific GP is subject to availability.

Appointments are booked to last 10 minutes. We can only deal with one problem in a consultation. If you have a complicated problem or several problems please inform the receptionist at the time of booking. A longer appointment will then be made.

We invite you to attend for a consultation with the practice nurse to discuss health issues.

Please bring the completed form with you when you register at this practice.