

**MANOR SURGERY MEDICAL QUESTIONNAIRE - PRIVATE & CONFIDENTIAL**

Welcome to the Manor Surgery.  
It would be helpful if you could complete a few details about your health:

Name..... First Language spoken.....  
Date of birth..... Occupation.....  
Height..... Weight.....

Please list any illnesses, accidents or operations that you have had in the past or are suffering from now.

Present:	Past:
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**Medication:**

Please list any medication that you are taking at present

**Allergies:**

Please list any drug/non-drug allergies

**Smoking Status:**

Are you a smoker?	Yes/No (please circle)
How many do you smoke per day?	
If you are an ex-smoker, when did you stop?	

**Alcohol intake:**

How many units of alcohol do you drink per week?.....

**1pt of reg beer = 2u, 1 can of lager /alcopop = 1.5u, glass of wine (175ml) = 2u, single spirits = 1u.**

Score *please circle as appropriate*

	0	1	2	3	4
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 -4 times per month	2 – 3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10 +
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

*If your score is 5 or more please make an appt. with the practice nurse* Total Score.....

**Standard drink is ½ pt beer, small (125mls) glass of wine, single measure of spirits**

**Family history:**

Has a close relative suffered a heart attack or had angina under the age of 60?	Yes/no (Please circle)
If yes, who?	
Has a close relative ever suffered a stroke?	Yes/no (Please circle)
If yes, who?	

**Women Only:**

When was your last cervical smear taken?	
Where was it taken?	
What was the result?	
Have you had a hysterectomy, if so when?	
Are you taking the contraceptive pill or receiving the contraceptive injection?	
Have you been fitted with a coil (IUD)?	

**Carers and Caring:**

Do you have a carer?	Carer's details	
Are you a carer?	Yes / No	If yes; Please ask for a form from reception so that we can help support you

**ETHNICITY** Please (✓) one box

- |   |  |
|---|--|
| <input type="checkbox"/> British or mixed British             | <input type="checkbox"/> Filipino                          |
| <input type="checkbox"/> White – Irish                        | <input type="checkbox"/> Other Asian background            |
| <input type="checkbox"/> Other White background               | <input type="checkbox"/> Mixed – White and Black Caribbean |
| <input type="checkbox"/> Black or Black British – Caribbean   | <input type="checkbox"/> Mixed – White and Black African   |
| <input type="checkbox"/> Black or Black British – African     | <input type="checkbox"/> Mixed – White and Asian           |
| <input type="checkbox"/> Other Black background               | <input type="checkbox"/> Other Mixed background            |
| <input type="checkbox"/> Asian or Asian British – Indian      | <input type="checkbox"/> Other Ethnic background           |
| <input type="checkbox"/> Asian or Asian British – Pakistani   | <input type="checkbox"/> Chinese                           |
| <input type="checkbox"/> Asian or Asian British – Bangladeshi | <input type="checkbox"/> Information declined              |

*Thank you for taking the time to complete this health questionnaire, the information will be added to you medical records.*