

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.....

Date of birth.....

Occupation.....

Are you a carer?
 Who do you care for?

Do you have a carer? (If yes, please give name & contact number)

Medical details:

Height.....

Weight.....

Please list any illnesses e.g. diabetes, asthma etc, accidents or operations that you have had in the past or are suffering from at present

PRESENT:	DATE/ ONSET:	PAST:	DATE/ ONSET:

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

Alcohol intake: (1 unit is 1 glass wine/half pint of beer/1 small measure of spirits)

How many units of alcohol do you drink per week?

(PLEASE COMPLETE ALSO COMPLETE OVERLEAF)

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)?	

<u>Children Only: Immunisation Status:</u>	Date & Place given?
BCG Vaccination	
DTaP/IPV/HIB & Men C – 2 months old	
DTaP/IPV/HIB & Men C – 3 months old	
DTaP/IPV/HIB & Men C – 4 months old	
MMR Vaccination	
Pre-School DTaP/IPV & MMR	
Single Men C Vaccination	

ETHNICITY Please (✓) one box

- | | |
|---------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> British or mixed British | <input type="checkbox"/> Chinese |
| <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"/> 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.