The Ivers Practice
Medical Health Questionnaire

Personal details (please circle where appropriate)

Title: Miss/ Mrs/ Ms/ Mr/ Other	Male / Female
Surname:	First Name:
Address:	
	Postcode:
Date of Birth:	Home Tel No:
Mobile Tel No:	Work Tel No:
Email Address	
Name of Next of Kin:	Tel No:

Are You:
White - British/Irish/ Other
Mixed - White & Black Carribean /White & Black African / White & Asian / Any other mixed background
Asian or Asian British - Indian / Pakistani / Bangladeshi / Any other Asian Background
Chinese or ethnic group - Chinese / other

- Place of Birth _____ Religion _____
- What is your first language _____ Do you need an interpreter Y / N
- Occupation(student, housewife, retired etc) _____
- Are you : Single Married Separated Divorced Widowed Co-Habiting Single Parent
- Do you have any children ? Y / N

Child's Name	Sex	Date of Birth	Registered Here
	M / F		Y / N
	M / F		Y / N
	M / F		Y / N
	M / F		Y / N

Your health

Have you or someone in your family ever had:

Condition	Yourself	Date	Relative (Mother, sister, Uncle etc)
High Blood Pressure			
Heart Attack or Angina			
High Cholesterol			
Stroke			
Diabetes			
Asthma			
Depression			
Cancer			

Are you allergic to anything ? (Specific medicines or foods ie penicillin or aspirin)

_____

Medication **(Please list all the medications you are taking)**

Name of Medication	Dose	What are you taking it for ?

Please continue on a separate sheet if necessary.

What is your weight ? _____ What is your height ? _____

Smoking Do you smoke ? Y / N

a) How many do you smoke per day ? _____
What kind ? (cigars, cigarettes etc) _____

b) Tick the statement below that best describes your intentions to stop smoking:

Not interested in stopping ☐
Thinking about stopping ☐
Ready to stop ☐
Trying to give up now ☐
Have made repeated attempted attempts to give up ☐

c) Have you ever smoked ? Y/N

When did you stop smoking ? _____

Alcohol – How much alcohol do you drink per week ? (On average)

- Pub measures of spirits _____
- Glasses of wine _____
- Pints of beer _____

Exercise – which sentence describes you ? (Please tick)

I visit a gym more than once a week ☐
I visit a gym twice a month ☐
I regularly walk (to work, at weekends, around town etc) ☐
I don't enjoy exercise ☐
I find exercise very difficult ☐

Vaccinations and immunisations

When was your last Tetanus booster ? _____

When was your last Polio booster ? _____

Have you had any other immunisations in the last 10 years ? _____

Women only

Do you use contraception ? Y / N If yes, what kind ? _____

Have you been immunised against Rubella (German Measles) ? Y/ N

When was your last smear ? _____ Was it normal ? Y / N

Where was the smear carried out ? (GP, Hospital, abroad etc) _____

Women over 50 only

Have you ever had x-ray screening for breast cancer ? Y / N

If yes, when was this done ? _____

Carers

Are you a carer ? Y / N

Does someone look after you ? Y/N

Further information about support for carers is available at reception – please ask.

Is there anything else we should know :

_____

_____

_____

_____

_____

Signature : _____

Date : _____

SHARING MEDICAL RCORDS

SHARE – IN means you allow your GP to access information shared by other health organisations who use the same system and provide you with care. For example a district nurse or a clinician in a community diabetic clinic. If you consent to SHARE - IN, your GP can see that information.

I DO / DO NOT * consent to SHARE – IN my health records.

Signed …… Date ……

SHARE – OUT allows your full GP record to be shared and seen by clinicians who are involved in your care and for them to see your shared information with your permission.

I DO / DO NOT * consent to SHARE – OUT my health records.

Signed …… Date ……

You can choose to SHARE-IN and SHARE-OUT, do one but not the other or consent to neither.

***** please delete as appropriate

Alcohol Consumption – AUDIT C

QUESTIONS						Your Score
Scoring System	0	1	2	3	4	
How often do you have a drink containing alcohol ?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female of 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Score _____

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive