Health Form

Today's Date:

Date of Birth: **Male/Female:**

Town and Country of Birth:

Main language spoken:

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?

Are you a veteran? YES/NO

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?
Do you want help to stop smoking? YES/NO
Consent to be referred to HELP ME QUIT YES/NO

HELP ME QUIT: 0800 085 2219
Or visit www.helpmequit.wales
ADVICE CARD GIVEN ☐

Do you want to discuss treatment with Nicotine Replacement Therapy?
YES / NO

How many units of alcohol do you drink per week?

If you drink more than 14 units – Women
21 units – Men
Would you like to discuss how to reduce your intake?
YES/NO

For further information go to:
www.nhs.uk/change4life

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

Do you do any form of exercise?
How many times per week?

THIS QUESTION IS FOR FEMALES ONLY
Have you had a Cervical Smear? YES/NO
Date:

Females who are 25 years and over are advised to have a smear every 3 years.

ID SEEN ☐
MHOL ☐
ACWY WANTS APPOINTMENT ☐
DECLINED ☐

(All Information given is added to Your Medical Record)

Surname: _____

Forenames: _____

Address: _____

_____

Post Code: _____

Contact Numbers:
(House and Mobile)
My Health Text **YES☐** **NO☐**

Email Address:

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

Is it Owned or Rented?

NEXT OF KIN DETAILS:

NAME: _____

RELATIONSHIP: _____

TELEPHONE NO: _____

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:

Drug Name **Dose** **How Many Times a Day**
_____
_____

Are you allergic to any medication that you know of?
(e.g. penicillin)

If yes, what? ……

Type of reaction (e.g. Rash) ……

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.

Year Past/Present

□ **Heart Attack** _____
□ **Angina** _____
□ **Stroke** _____
□ **High Blood Pressure** _____
□ **Diabetes** _____
□ **Emphysema/COPD** _____
□ **Epilepsy** _____
□ **Thyroid Disorder** _____
□ **Cancer** _____
□ **Asthma** _____
□ **Depression** _____
□ **Mental Health Problem** _____
□ **Dementia** _____
_____

□ T.B.(Tuberculosis) _____
□ Jaundice _____
□ Skin Disease _____
□ Stomach Ulcer _____
□ Kidney Disease _____
□ Hay Fever _____
□ Malaria _____
□ Hepatiis B _____
□ Hepatitis C _____
□ HIV _____

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:
If **YES**. Please tick appropriate item.

□ **Impaired Hearing/Deaf** _____
□ **Speech Impaired**_____
□ **Partially Sighted/Blind**_____
□ **Mobility Impaired** _____
□ **Learning Disabilities**_____

Do you require any specific support? YES/NO
If yes please state ……..

You will be invited for a appointment if you have any Learning Disabilities.

Carers

Are **YOU** a Carer?_____
Who do you Care for?_____
Is this person registered here?_____
Do you **HAVE** a Carer?_____
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 information on the health of your family and any illnesses.

Parents:

	Age	State of Health
Mother		
Father		

Brothers or Sisters:

Boy/Girl	Age	State of Health

Have you had a 'ACWY MENINGITIS' vaccination?

YES/NO DATE …….

If 'No or Not Sure' and you are a 1ST YEAR STUDENT please book appointment with practice nurse for a vaccination.

Have you had a second 'MMR' vaccination?

YES/NO DATE …….

Have you had a BCG/HEAF Test?

YES/NO Date ……

Do you have a BCG Scar? YES/NO

Have you been tested for:

		RESULT
HEPATITIS B	**YES/NO**	**NEG / POS**
HEPATITIS C	**YES/NO**	**NEG / POS**
HIV	**YES/NO**	**NEG / POS**

Do you have a tattoo? YES/NO

Have you ever had a blood transfusion? YES/N

Information regarding who is at risk of Hepatitis B,C or HIV is available on the practice website www.cathayssurgery.co.uk

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 a double appointment will then have to be made.

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