

# 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: 1<sup>st</sup> year 2<sup>nd</sup> year 3<sup>rd</sup> 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

\_\_\_\_\_

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## 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](http://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](http://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.

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ID SEEN

MHOL

ACWY WANTS APPOINTMENT

DECLINED

**(All Information given is added to Your  
Medical Record)**

Surname: \_\_\_\_\_

Forenames: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Post Code: \_\_\_\_\_

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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:

<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? .....

Type of reaction (e.g. Rash) .....

Have you misused drugs? .....

If yes which drug? .....

How often?.....

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## 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 |
|--|-------|--------------|
| <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               | _____ | _____        |
| <input type="checkbox"/> Hepatiis B            | _____ | _____        |
| <input type="checkbox"/> Hepatitis C           | _____ | _____        |
| <input type="checkbox"/> 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	_____	_____
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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 1<sup>ST</sup> 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	<b>YES/NO NEG / POS</b>
HEPATITIS C	<b>YES/NO NEG / POS</b>
HIV	<b>YES/NO NEG / POS</b>

Do you have a tattoo? **YES/NO**

Have you ever had a blood transfusion? **YES/N**

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Information regarding who is at risk of Hepatitis B,C or HIV is available on the practice website [www.cathayssurgery.co.uk](http://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.