**GENERAL HEALTH QUESTIONNAIRE**

Thank you for applying to join Shakespeare Surgery. We are interested in your general health and up to date information will help us decide what initial assessment you need. If you could please fill out the following questionnaire accurately and fully. If you are unsure of an answer leave that bit blank.

Title ……. First Name(s)………………………Surname…………………………

Date of Birth ………….. Marital Status …………… NHS Number ………………

Address ……………………………………………………………………………

……………………………. Post Code ………….. Telephone Number ……………

The Dept of Health asks us to gather ethnic group data at registration. Please can you indicate an answer by ticking one response

British .9i0
Irish .9i1
Other white British .9i2
White and Black Caribbean .9i3
White and Black African .9i4
Caribbean .9iB
African .9iC
Asylum Seeker .13ZN
Other (Please state what) …………….. .9iF
Not Stated .9iG
White and Asian .9i5
Other Mixed Background .9i6
Indian or British Indian .9i7
Pakistani or British Pakistani .9i8
Bangladeshi or British Bangladeshi .9i9
Other Asian Background .9iA
Other Black Background .9iD
Chinese .9iE
Decline to answer .9SI

Have you had/still have any of the following ?

| | | | | | |
|---|---|---|---|---|---|
| Angina | YES/NO | Diabetes | YES/NO | Cancer | YES/NO |
| Blood Pressure | YES/NO | Depression | YES/NO | Bronchitis/Asthma | YES/NO |
| Epilepsy | YES/NO | Stroke | YES/NO | Heart Attack | YES/NO |
| Arthritis | YES/NO | Thyroid Problem | YES/NO | Tuberculosis | YES/NO |
| Stomach Ulcer | YES/NO | Other Illnesses? …………………………….. | | | |

Any Operations? ……………………………………………………………………

Can you list the medication that the Dr is giving you that you are taking at present?

………………………………………………………………………………………

………………………………………………………………………………………

………………………………………………………………………………………

Are you taking any medication other than that given by the Dr? ……………………..

…………………………………… Any Medications Allergic To..………………...

Are you under the care of a Hospital at present YES/NO

Details Specialist Name Hospital Diagnosis

………………………………………………………………………………………

If known current

HEIGHT ……………. WEIGHT ……………….. Blood Pressure ………..

Do you smoke YES/NO If yes how much/many per day ………………….

Did you used to smoke YES/NO If yes how much/when did you stop ……………….

Do you drink alcohol?YES/NO If yes what do you drink and how many per week…...

…………………………………………………………………………………………..

Is there any family history of any Health problems (e.g. lung/heart problems/Blood pressure etc) ……………………………………………………………………………

…………………………………………………………………………………………

Are you working YES/NO If yes what is your job? …………………………..

Has your health affected your ability to work? YES/NO If yes in what way…………

…………………………………………………………………………………………

Are there any other general problems affecting you that you think we should know about?

…………………………………………………………………………………………

…………………………………………………………………………………………

Women Only

Are you currently pregnant? YES/NO Have you been Pregnant? YES/NO

Any Problems with pregnancy (miscarriages, difficult deliveries etc) YES/NO

Details ……………………………………………………………

Are you using any birth control YES/NO? Details …………………………..

When was your last smear? ……………………………….

Children Only

Are you up to date with all immunisations YES/NO
If no which have you not had? ……………………………………………

**Where did you hear about Shakespeare Surgery from? (please tick all that apply)**

Recommendation from family/friend? Internet? Primary Care Trust?

Local Hospital? Newspaper Advert? Leaflet? Other surgery in building?

Elsewhere? (please specify) …………………….

Next of Kin: ………………………Telephone Number……………………..

Thank you for helping in this health review. Please return the form to reception for processing