COURTYARD SURGERY
New Patient Registration Health Questionnaire (Adults 16 +)

Name:…… **D.O.B**:…….…….. **Date**: ...……..…….

What is your: Sex: (M/F) …… Height ……..…… **Weight** ……

Do you have a mobile telephone contact number? …….

☐ **Tick here to confirm that we may contact you by SMS (Text)**

Do you smoke: Yes/No If yes, how many per day: ……..……

Have you ever smoked: Yes/No If yes, how many per day: ……..……..
If yes, date of stopping: ……

Do you drink alcohol: Yes/No

If you drink alcohol please answer the following three questions: (please circle)

1	**How often do you have a drink that contains alcohol?**	**Never**	**Monthly or less**	**2 - 4 times per month**	**2 – 3 times per week**	**4+ times per week**
2	**How many standard alcoholic drinks do you have on a typical day when you are drinking?**	**1 – 2**	**3 – 4**	**5 – 6**	**7 – 9**	**10+**
3	**How often do you have 6 or more standard drinks on one occasion?**	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**

Based on your answers above how many units of alcohol do you drink per week: ……
(1 pint beer = 2 units. 1 pub spirit measure = 1 unit. 1 small glass of wine = 1 unit)

Do you or anybody in your family suffer from: (please tick as appropriate & include date of diagnosis if applicable to you where possible)

	You	**Date of Onset**	**Your family**
Asthma			
COPD			
Type 1 Diabetes			
Type 2 Diabetes			
Heart Disease – Under 60			
Heart Disease – Over 60			
Hypertension			
Stroke			
Epilepsy			
Breast Cancer			
Bowel Cancer			
Ovarian Cancer			
Prostate Cancer			
Cancer (please indicate type)			
Hip Fracture (mother Under 75)			

Have you had/do you have any other major illnesses or operations? (particulars including dates)

……

……

Date of last cervical smear: …… **Result:** ……

If pregnant please give estimated date of delivery: ……

Do you have any allergies: (please specify) ……

……

Do you take regular exercise: Yes/No

- ☐ Light - walking
- ☐ Moderate - Gym/Regular Sport
- ☐ Heavy – Serious Competitive Sport
- ☐ Avoids even trivial exercise
- ☐ Exercise physically impossible

Do you take regular medication prescribed by your doctor or purchased over the counter.

Please list:

Name of Medication	Dose

CARERS

Do you look after someone? …….. **Does someone look after you?** …….

If yes to either of these questions please ask at reception for a Carers Registration Form.

Please bring a urine sample with you to the surgery.