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

Name:		. <b>D.</b>	D.O.B: Date:							
What is your: Sex: (M/F)		. He	Height Weight							
Do you have a mobile telephone contact number?										
Do you smoke: Yes/No		lf y	If yes, how many per day:							
Have you <u>ever</u> 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				
	ed on your answers above how maint beer = 2 units. 1 pub spirit measu									

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 specif	y)					
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 prescribe	d by your doctor or purcha	ased over the counter.				
Please list:						
Name of Medication	on	Dose				
NOMINATED PHARMACY						
Do you have a nominated pharmacy? You	es/No Name of Pharma	cy:				
Do you wish to continue with this pharma	acy? Yes/No					
If you have a nominated pharmacy but nomination and we will amend your comp		please advise us of your new				
Name of New Pharmacy:						
CARERS						
Do you look after someone?	Does someone look a	fter you?				
If yes to either of these questions please	ask at reception for a <u>Care</u>	rs Registration Form.				