Kessington Medical Centre

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NEW PATIENT HEALTH QUESTIONNAIRE			
Please complete this and bring with you to the Health Promotion Clinic along with a fresh urine sample			
Name (BLOCK LETTERS)		**Date of Birth**	
Address		**Email address: BLOCK LETTERS**	
	We use text messages for appointment reminders, your health & our services	**Consent for text messages**	Please Tick to consent ☐
Home tel no		**Mobile number**	
Marital status		**Occupation**	
Next of kin to be contacted in emergency			
Name (BLOCK LETTERS)		**Home tel no**	
Address		**Mobile number**	

Please use back page for any continuation of answers

1. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:-			
	YES	**NO**	**Details (including dates)**
a) Heart problems			
b) Breathing problems			

c) Diabetes			
e) High Blood Pressure			
f)Stroke			
g)Blood problems			
h)Gut problems			
i)Cancer			
j)Mental health issues including stress/depression etc			
k)Operations			
l)Other			

2. IS THERE A FAMILY HISTORY OF ANY OF THE ABOVE A-L? **YES** □ **NO** □

If YES PLEASE LIMIT THIS TO IMMEDIATE FAMILY AND STATE APPROXIMATELY AT WHAT AGE? (BEFORE OF AFTER > 60 YEARS)

Details

3 ARE YOU ON ANY PRESCRIBED MEDICATION? **YES** □ **NO** □

Please state name of drug, dose and reason for taking it.

Please attach prescription re-order list if available.

If you are on medication please make an appointment with doctor as well as the nurse.

Drug Name	**Dose**	**Frequency**	**Reason**

4. DO YOU HAVE ANY ALLERGIES? Please list below **YES** □ **NO** □
e.g. Penicillin, Hay Fever

DRUG ALLERGIES - Please detail name of drug, type of reaction and dates

NON-DRUG ALLERGIES– Please detail substance, type of reaction and dates

5. SMOKING STATUS. PLEASE TICK APPROPRIATE BOX.

I have never smoked □

I am an ex smoker □ Date stopped: _____

I am a current smoker □ Number smoked per day: _____

Are you interested in stopping smoking? YES □ NO □

6. IN THE AVAERAGE WEEK, HOW MANY UNITS OF ALCOHOL DO YOU DRINK?_____ Units
(1 pint of beer is 2 units, a measure of spirit 1 unit, a small glass of wine 1 unit).

7. EXERCISE (IN THE PAST WEEK)

(a) In the past week on how many days have you been physically active for a total of 30 minutes or more? _____DAYS

(b) Have you been active for at least 2.5 hours over the course of the past week? YES □ NO □

(c) Are you interested in being more physically active? YES □ NO □

DATE _____

SCREENING INFORMATION

Men answer Section 8 AND 12-13 only. Women answer ALL sections.

8 .Immunisation **Have you been immunised against:**

a. Tetanus in the last 10 years YES □ APPROX DATE _____ NO □

Was this given by a hospital or a GP? Hospital □ GP □

b. Polio in the last 10 years YES □ APPROX DATE _____ NO □

c. If a child, is your immunisation programme up to date YES □ NO □

Women Only

9.Cervical Screening (25 years- 70 years)

If you are a woman over 25, have you had a cervical smear in the last 3 YES □
If yes, please give details below NO □

Date	**Result**	**Where Performed (Hospital or GP)**

10. **Breast Screening**

Have you had a Mammogram (Breast X-ray)? YES □ NO □

If so, please give details below.

11. Do you use any form of contraceptive? If so, please specify.

(We appreciate that this is a sensitive area and will be treated with confidence. If will help your medical management, however, if your doctor is aware of this information.)

12. Have you had a Bowel Screening Test recently? If so, please specify.

ADDITIONAL INFORMATION:

13. Do you have any problems not referred to above which you would like your doctor to know about?

Baseline Measurements (Please leave blank – to be completed at the Clinic)

Height Ft _____Ins_____ Metres _____

Weight St_____lbs_____ Kgs _____

BMI _____

Blood Pressure / Date _____

Urine Analysis

PLEASE USE THIS SHEET IF NECESSARY FOR FURTHER INFORMATION