June 2014

NEW REGISTRATION HEALTH CHECK

Welcome to Dr Seyan's Practice. As a new patient we would like to offer you a health check. This involves seeing the Health Care Assistant and telling them about your health and having a short physical examination. Please note your registration will not be complete unless you have a health check.

Date form completed:

Last Name:	First Name:
Date of Birth:	Title:
Marital status: (Please circle) Single / Married / Co-habiting	
Ethnic Group: For data collection purposes please circle your ethnic group British or mixed British Irish Other White background White and Black Caribbean White and Black African White and Asian Other mixed background Indian or British Indian Pakistani or British Pakistani Bangladeshi or British Bangladeshi Other Asian background Caribbean African Other Black background Chinese Other Ethnic category not stated	
Is English your first language? If no, which language is?	❑ Yes ❑ No
Employment status (please circle) Employed – profession _____ Unemployed Retired Housewife Student Unable to work	

About you **Have you ever suffered from:**		**Family History** **Do you have a family history of any of the following:**	
Heart Attack	**Yes/No**	**Heart Attack**	**Yes/No**
Angina	**Yes/No**	**Angina**	**Yes/No**
Heart Failure	**Yes/No**	**Heart Failure**	**Yes/No**
Stroke	**Yes/No**	**Stroke**	**Yes/No**
Blood pressure	**Yes/No**	**Blood Pressure**	**Yes/No**
Diabetes	**Yes/No**	**Diabetes**	**Yes/No**
Asthma/Eczema/Hayfever	**Yes/No**	**Asthma/Eczema/Hayfever Relative**	**Yes/No**
Cancer	**Yes/No**	**Cancer**	**Yes/No**
Blindness/Glaucoma	**Yes/No**	**Blindness/Glaucoma**	**Yes/No**

Are you a smoker? ❑ Yes ❑ No	**Are you an Ex-Smoker** ❑ Yes ❑ No
(please circle) Cigarettes Pipe Cigars Rolling	**How many per day** 1 ❑ 2-9 ❑ 10-19 ❑ 20-39 ❑ 40+ ❑

How much regular sport or exercise do you undertake on a weekly basis?	Squash Tennis Swimming Jogging Walking Aerobics Other (please state)

Please list serious all operations, disabilities or other chronic illnesses

When	What

MEDICATION – Please list below any drugs, medicines or contraceptive pills you are taking and bring your repeat prescription form or boxes of medication along to your health check

ALCOHOL CONSUMPTION

QUESTIONS	SCORING SYSTEM 0	1	2	3	4	YOUR SCORE
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	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

ALLERGIES

Please detail below any tablets or substances which you are allergic to:

VACCINATIONS & IMMUNISATIONS

Have you had a tetanus injection in the past 10 years? Yes/No When _____

Have you had a polio booster in the last 10 years? Yes/No When _____

Do you have a learning difficulty? Y/N **If Yes please state**	

Height	**Weight**

LADIES (age 20 to 65)

Have you had a hysterectomy? Yes / No Have you had a cervical smear? Yes/No

Date Smear Taken	At GP/Clinic	Result	Recall Date