Viewfield

Welcome to our practice.

Please help us to look after your health by answering the following questions

Date _____

About You:

Surname _____Title _____

Forenames _____ Date of Birth_____

Address_____

Post Code _____Telephone _____

Ethnicity:

White Scottish___ Other White British ___ White Irish ___ Other White ___ Any Mixed Background ___

Indian ___ Pakistani ___ Bangladeshi ___ Chinese ___ Other South Asian ___ Caribbean ___ African ___

Black Scottish/Other Black ___ Other Ethnic Background ___

Sex: Male/Female Status: Single/Married/Cohab/Separated/Divorced/Widowed

Number of Children: Male ___ Female ___

Employment _____ Housing: House/Flat/Maisonette/Other_____

About Your Lifestyle:

Smoker Yes / No Number per day ____

Ex Smoker Yes / No Number per day ____ Year stopped _____

Never Smoked Yes/No

Alcohol per week beer / lager _____ wine _____ spirits _____ total _____
please use UNITS: 1 Unit is half pint beer, glass of wine or single measure of spirit.

Diet Mixed / Vegetarian / Vegan / Other _____

Exercise Regular / Moderate / Little / None

Do you give consent for the practice to e-mail or text non confidential material ☐ **Yes** ☐ **No**

Preferred mode of contact ☐ **e-mail** ☐ **text**

E-mail address_____ **Mobile No**_____

Are you a carer for another person **Yes/No**

Do you receive care from another person **Yes/No**

About Your Health:

Past Illnesses	Date	Past Illnesses	Date
Diabetes		Cancer	
Heart Disease or Heart disorders		Mental Health Problems	
Raised BP		Depression	
Asthma		Dementia	
COPD		Stroke/TIA	
Epilepsy		Thyroid problems	
Kidney Problems		Learning Disabilities	

Other Serious Illness or Operations	Date

Your Present Medication:

Name	Strength	How Often

Immunisations:

Immunisation	Date	Immunisation	Date
Tetanus		Rubella (German Measles)	
Polio		Typhoid	
Hepatitis A		Meningitis	
Hepatitis B		Yellow Fever	

About Your Family's Health:

Has anyone in your family suffered from any of these illnesses:

Illness	Who	Age
Heart Attack		
Angina		
Diabetes		
Stroke		
Cancer		
High Blood Pressure		
Tuberculosis (TB)		
Migraine		
Asthma		
Glaucoma		
Other:		

For Women Only:

Date of last Cervical Smear _____ Where done_____ Result_____

Date of last breast screening/examination _____

Ages of children _____ Miscarriages _____

Method of contraception _____

Age of menopause _____

Thank you for your help