HILLHEAD FAMILY PRACTICE

Dr Grainne Bonnar Dr Aidan Thompson Dr Evanna Fitzsimons
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INFORMATION WILL BE TREATED CONFIDENTIALLY
KINDLY COMPLETE AND RETURN THE QUESTIONNAIRE

NAME (Mr/Miss/Mrs/Ms)	**Date of Birth**
ADDRESS	**Marital Status**
	Telephone Number
POSTCODE	**Mobile Telephone**
Occupation	**Work Telephone**
Email Address	

Height	**Weight**

HOW MUCH ALCOHOL DO YOU DRINK PER WEEK (Please enter quantity)

DO YOU TAKE ALCOHOL (answer YES or NO)	**NONE**	**BEER (Pints)**	**WINE (Glasses)**	**SPIRITS (Shorts)**

SMOKING STATUS?

	YES	**NO**
Do you smoke?		
If NO, have you ever smoked?		
If YES, when did you stop smoking?		
If you currently smoke, how many cigarettes do you smoke per week?		

DO YOU HAVE/HAD ANY SERIOUS MEDICAL CONDITIONS?

	YES	**NO**		**YES**	**NO**
ANGINA			ASTHMA		
HEART ATTACK/STROKE			BRONCHITIS		
HIGH BLOOD PRESSURE			ECZEMA		
CANCER			EPILEPSY		
RHEUMATIC FEVER			NERVOUS DISORDERS		
DIABETES			KIDNEY DISEASE		
OTHER			ARTHRITIS		

Have you had any operations?	
Do you have any allergies?	
Are you allergic to any medicine?	

Name of Carer/Next of Kin	
Telephone no. of Next of Kin	

Family History
Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease.

Current Medications (Please list)			
NAME	**STRENGTH**	**DOSAGE/HOW OFTEN**	**WHY ON MEDICATION**

Medication bought over the counter (please detail)

WOMEN ONLY

Date of last smear	
Where taken (GP or other)	
Result if known	

Do you use any method of family planning? (please tick)

None	Contraceptive Pill	Coil	Other Methods

	YES	NO	HOW MANY
DO YOU HAVE CHILDREN			
HAVE YOU EVER HAD A CAESARIAN SECTION			
HAVE YOU EVER HAD A MISCARRIAGE			
HAVE YOU EVER HAD A CERVICAL SMEAR			

CHILDREN ONLY

Vaccinations Please tick if received	1ST	2ND	3RD	MMR	HIB	MEN C	Pre-School Booster	MMR2

ADULTS ONLY

Enter dates of immunisations if known	RUBELLA	TETANUS	OTHER

We would like to invite you to come to the surgery for a consultation with the healthcare assistant, Lisa Grant, so that she can record your medical history and make a note of your basic measurements. You may be seen by Lisa from 8.30am to 10.30am. This is an open session.

Signature:_____ **Date:**_____