

**SHAWLANDS SURGERY**  
**HEALTH SCREENING QUESTIONNAIRE**

***YOUR PERSONAL DETAILS***

**SURNAME** \_\_\_\_\_ **FORENAMES** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_

**ETHNIC ORIGIN** \_\_\_\_\_ **MARITAL STATUS** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_

**NEXT OF KIN  
- NAME AND  
CONTACT  
INFO** \_\_\_\_\_

**PREVIOUS  
G.P.** \_\_\_\_\_

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

***FAMILY HISTORY***

Have any of your parents, brothers or sisters suffered from any hereditary diseases, such as heart disease, asthma, high blood pressure, diabetes, stroke or epilepsy? (Please give details)

Are you aware of any other family tendency to illness?

Are you a Carer? If so, who do you care for?

Are you cared for? If so, by whom?

**PLEASE TURN OVER ->**

## ***SOCIAL HISTORY***

1. Do you currently smoke (cigarettes, pipe, cigars)?

If yes, how many per day?

If you are an ex-smoker, when did you stop?

2. Do you drink alcohol?

If so, how many units do you normally have per week? (1 unit = ½ pint beer/1 small glass of wine/1 small pub measure of spirits)

## ***MEDICAL HISTORY***

1. Have you had any operations or serious illnesses? (Please give approximate dates & details)

2. Are you currently attending any hospital clinics or your GP? (Please give details)

3. Are you currently taking any medication? (Please list below)

4. Are you allergic to any medication? (Please list below)

5. When did you last have a: Tetanus / diphtheria vaccination?

Polio vaccination?

Cervical smear test? (females only!)

***Thank you for your help***