Medical History Contd.

Are you taking or using any medication at present?

Type	Dosage

Are you now under hospital treatment or on the waiting list for any surgical procedure?

☐ YES ☐ NO

Has anyone in your close family ever had cancer?

Relationship To You	Type of Cancer	Age At Onset

Do you suffer from any recurring condition?	Your Age At Onset	Is there a family history of these?	Relationship To You	Their Age At Onset
Asthma	.....		.....	.....
Eczema	.....		.....	.....
Hay Fever	.....		.....	.....
Bronchitis	.....		.....	.....
Fits	.....		.....	.....
Mental Depression	.....		.....	.....
Other Psychiatric Problems	.....		.....	.....
Diabetes	.....		.....	.....
High Blood Pressure	.....		.....	.....
Angina/Heart Attack	.....		.....	.....
High Cholesterol	.....		.....	.....
Glaucoma	.....		.....	.....
Stroke	.....		.....	.....

Have you any major handicap, disability, social problem, or other matter you would like your doctor to know about?

Your height

Your current weight

Have you been immunised against:

		Year			Year
Diptheria	☐	.....	Meningitis C	☐	.....
Tetanus	☐	.....	Other	☐	.....
BCG	☐	.....			
Polio	☐	.....			
Rubella *(German Measles)*	☐	.....			

** Please give details:*

Are you allergic or sensitive to anything such as penicillin, aspirin, plaster, etc.

Allergy	What Does It Do To You?

Do you smoke?	No. Per Day?	If non-smoker, did you ever smoke?	No. Per Day?	Year Stopped
☐ YES* ☐ NO		☐ YES* ☐ NO		
**Please tick those that apply:*		**Please tick those that apply:*		
☐ Cigarettes	.....		.....	.....
☐ Cigars/Cigarillos	.....		.....	.....
☐ Pipe	.....		.....	.....

Do you drink alcohol? ☐ YES ☐ NO

If yes, what is your average weekly consumption?
One unit = 1/2 pt. beer, or 1 glass wine, or 1 measure spirit
..... Units

Do you exercise?

☐ Regular Vigorous Exercise ☐ No Regular Exercise But An Active Lifestyle

☐ Moderate Exercise ☐ Cannot Exercise

Is there anything the doctor should know about your diet?

WESTONGROVE PARTNERSHIP

ASTON CLINTON SURGERY
BEDGROVE SURGERY
WENDOVER HEALTH CENTRE

CONFIDENTIAL

HEALTH DATA FORM FOR ADULTS

*Please use a ballpoint pen and **PRINT** clearly*

BASIC REGISTRATION INFORMATION

Present surname

Previous surname (*if any*)/Maiden name

Forenames (*underline name by which usually known)*

Address

Postcode

Telephone no: HOME
WORK
MOBILE

Date of birth
☐ DAY ☐ MONTH ☐ YEAR

Place of birth

Occupation

Contact In Case of Emergency

Name

Address

Tel No:

Carer Status

Are you a carer? YES NO
Who do you care for? .....
Do they live with you? YES NO
Their Age: ..... Male/Female
or
Are you cared for? YES NO
by Relative or Friend, etc. .....

Ethnicity

This information can help us plan to meet the needs of the community and ensure that everyone has equal access to the health care we provide. The classification is entirely voluntary but will help us to provide a better service.

A White British	☐	J Pakistani	☐
B White Irish	☐	K Bangladeshi	☐
C Any other White background	☐	L Any other Asian background	☐
D White and Black Caribbean	☐	M Caribbean	☐
E White and Black African	☐	N African	☐
F White and Asian	☐	P Any other Black background	☐
G Any other mixed background	☐	R Chinese	☐
H Indian	☐	S Any other ethnic group	☐

Medical History

Please list below any major illnesses, accidents, or operations. Do not include colds, sore throats, 'flu, etc. unless they recur persistently.

Year	Condition/Operation	Hospital (if applicable)