

# Wollaton Park Medical Centre

## Confidential Medical Questionnaire

Welcome to the practice. Please help us by completing as much of this questionnaire as possible.

Name:	Male/Female:	Date of Birth: Place of Birth:
Address:		
Post Code:	Landline:	Mobile:

Current GP's Name:
Medical Centre:
NHS Number:

### Personal History

*Have you ever had any of the following?:*

Any Serious Illness	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Any Allergic Reaction	<input type="checkbox"/>	Anxiety Attacks	<input type="checkbox"/>	Surgical Operation	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Tropical Disease	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>
Serious Depression	<input type="checkbox"/>	Any Disability	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Fits or Fainting	<input type="checkbox"/>

If any of the above conditions or any other medical problem still trouble you then please give details below:

**Immunisations:** *please give approximate dates*

Tetanus:	Polio:
TB:	Rubella:

### Lifestyle:

Have you ever smoked? YES/NEVER	If YES how much do you smoke each day?
How much alcohol do you drink each week?:	
Height:	Weight:
How often do you exercise?    Everyday <input type="checkbox"/> Once a Week <input type="checkbox"/> Not Often <input type="checkbox"/>	
Describe your diet <i>e.g. vegetarian, normal etc</i>	
Are you allergic to any drugs?	
Have you ever lived or worked abroad?	Yes/No
Have you ever had a blood transfusion abroad?	Yes/No
Do you have any allergies?	
Is there anything in your lifestyle that might have put you at risk of HIV/Hepatitis B?	
Has anyone in your immediate family had:      Diabetes <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> HIV <input type="checkbox"/>	
Tuberculosis <input type="checkbox"/> Heart Attack/Stroke before the age of 60 <input type="checkbox"/> High Cholesterol <input type="checkbox"/>	

### Ladies Only:

When did you last have a smear?:	Are you using any birth control?:
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Please indicate your ethnic group by circling the appropriate group number

Group No	Group	Category	Code Set 2
1	White	British	9i0..
2	White	Irish	9i1..
3	White	Any other White background	9i2..
4	Mixed	White and Black Caribbean	9i3..
5	Mixed	White and Black African	9i4..
6	Mixed	White and Asian	9i5..
7	Mixed	Any other mixed background	9i6..
8	Asian or Asian British	Indian	9i7..
9	Asian or Asian British	Pakistani	9i8..
10	Asian or Asian British	Bangladeshi	9i9..
11	Asian or Asian British	Any other Asian background	9iA..
12	Black or Black British	Caribbean	9iB..
13	Black or Black British	African	9iC..
14	Black or Black British	Any other Black background	9iD..
15	Other Ethnic Groups	Chinese	9iE..
16	Other Ethnic Groups	Any other ethnic group	9iF..
17	Ethnic Group Not Stated	Ethnic category not stated	9iG..