Arthurstone Medical Centre, Arthurstone Terrace, Dundee

##### Health Questionnaire

###### MALE/FEMALE/CHILD

|  |  |
| --- | --- |
| FORENAME(S) | SURNAME |
| Maiden/Previous Name: |
| Date of Birth | Nationality |
| Address | Previous Address |
| TELEPHONE NUMBER | Occupation |
| Name & Address of last doctor | Marital StatusSingleMarried DivorcedWidowedSeparatedCohabiting | Children – Number/Sex/Ages |
| FEMALES ONLYWhen did you last have a cervical smear: Date \_\_/\_\_/\_\_ Result\_\_\_\_\_\_\_\_\_\_\_ Was the smear taken at……GP / CLINIC / HOSPITAL**Parity \_\_\_+\_\_\_****Have you had any breast screening?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Any other information about your health?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Do you have any problems with your health at present?  |
| What illnesses and injuries have you had in the past? |
| What medicines do you take at present? |
| Do you require repeat medication in the next 2 weeks? | **Yes** | **No** |
| **YOU WILL REQUIRE AN APPOINTMENT WITH A DOCTOR BEFORE A PRESCRIPTION IS ISSUED FOR ANY REGULAR MEDICATION** |
| Do you have any allergies to drugs or anything else? |
| Are there any problems or illnesses that your family has or had? FATHERMOTHERBROTHER(S) / SISTER(S)1]2]3]4] |
| When did you last have a - TETANUS INJECTION \_\_\_/\_\_\_/\_\_\_ - POLIO BOOSTER \_\_\_/\_\_\_/\_\_\_ |
| Do you smoke – Yes / No | Have you ever smoked Yes / No  | Do you exercise regularly Yes / No |
| Do you have a well balanced diet – YES / NO |
| Children OnlyParents Name:MotherFatherDate Of Immunisation: |

All Patients

|  |  |  |
| --- | --- | --- |
| Do you care for someone in your family or a close friend? | Yes | No |
| Does someone care for you? | Yes | No |
| Would you like to be referred to Social Services for a carer’s assessment? | Yes | No |
| Would like to be referred to the Princess Royal Trust Carers centre? | Yes | No |

ACCESS

In times of emergency, for house calls or during out of hours a doctor may need to visit you at home.

|  |  |  |
| --- | --- | --- |
| Is access to your home or residence controlled by a key pad or key safe | Yes | No |
| Who can the doctor contact to gain access if required? |
| Name:Relationship:Address:Tel No: |

***Important: Do not record any key pad or key safe codes on this form.***

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care. More information about it is on the back of this form but please ask a member of staff if you need more explanation.

Do you need an interpreter or sign language support? [ ] Yes [ ] No

If you do need an interpreter what language do you speak?

Please state …………………………………………………….

What is your ethnic group?

Choose ONE section from A to E then tick ONE box which best describes your ethnic group or background

A White

□ Scottish

□ English

□ Welsh

□ Northern Irish

□ British

□ Irish

□ Gypsy/Traveller

□ Polish

□ Any other white ethnic group, please write in …………………………………..

B Mixed or multiple ethnic groups

□       Any mixed or multiple ethnic groups

C Asian, Asian Scottish or Asian British

□    Pakistani, Pakistani Scottish or Pakistani British

□     Indian, Indian Scottish or Indian British

□     Bangladeshi, Bangladeshi Scottish or Bangladeshi British

□    Chinese, Chinese Scottish or Chinese British

□   Other, please write in……………………………………………….

D African, Caribbean or Black

□       African, African Scottish or African British

□       Caribbean, Caribbean Scottish or Caribbean British

□   Black, Black Scottish or Black British

□   Other, please write in…………………………………………………………………

E Other ethnic group

□     Arab

□    Other, please write in………………………………………………………………..

If you do not wish to give this information, please tick here [ ]