Brookfield Park Surgery Health Questionnaire

Name: DOB:

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……

Personal Medical History…..

Type of Birth:
(eg normal, forceps, CaesareanIf under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed if under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles		BCG (TB)	
MMR		Meningitis	

Immunsation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:
Blood Pressure:	Waist Circumference: cm

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No
If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐ Pipe

How many cigarettes/ Cigars do you smoke daily ☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like help to quit smoking? ☐ Yes ☐ No

Lifestyle exercise ……

What exercise do you do?
Heavy/Moderate/Light/No Exercise (please circle)

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Other (please state):
☐ Decline to state

Next of kin ……

Name:

Tel. contact number:

Relationship:

Where you have provided information on how to contact you, can you confirm you are happy for Brookfield Park Surgery to contact you by the following:

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

Signature ……

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐