HOWICK HEALTH & MEDICAL CENTRE
Medical Information Questionnaire

Please hand this form to Reception or your Doctor

Surname: _____ **First Name:** _____

Date of Birth: _____ **NHI:** *(If known)* _____

Do you have a Community or High Use Health Card? ☐ Yes ☐ No

1. Do you have any of the following medical problems?

Diabetes	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Heart disease or problems	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Other lung or respiratory disease or problems	☐ Yes ☐ No
Kidney disease or problems	☐ Yes ☐ No
Liver disease or problems	☐ Yes ☐ No
Bowel disease or problems	☐ Yes ☐ No
Joint disease or problems, arthritis	☐ Yes ☐ No
Depression and/or anxiety	☐ Yes ☐ No
Other mental health Illnesses	☐ Yes ☐ No
Any other medical problems not listed above?	

2. Please list any regular medications/over the counter medications that you take:

_____

_____

_____

3. Have you had any operations? If yes, please list below ☐ Yes ☐ No

_____

_____

_____

4. Are you allergic to any medications? If yes, please list below ☐ Yes ☐ No

_____

_____

_____

5. **Are there any illnesses in your family eg cancers, breast, bowel, prostate, melanoma etc?**
If yes, please list below ☐ Yes ☐ No

_____

_____

_____

6. **Do you currently smoke/vape?** ☐ Yes ☐ No

Have you ever smoked/vaped? ☐ Yes ☐ No

If yes, how many per day for how many yrs (approx.) _____

7. **Do you drink alcohol?** ☐ Yes ☐ No

a. How many days in a month do you drink an alcoholic drink? _____

b. How many standard alcoholic drinks on average do you have when you are drinking?
(standard drink = 100m l wine, 330ml beer bottle, 1 shot spirits) _____

c. How often in a month do you have 6 or more drinks on one occasion? _____

8. **When was your last Tetanus injection?** _____

9. **Females when was your last cervical smear?** (If applicable)

Abnormal smear in the past and when? _____

10. **Do you agree for the practice to contact you by email/text?** ☐ Yes ☐ No

11. **Do you agree to the use of transcription software use in the consults?** ☐ Yes ☐ No

12. **How did you hear of us?**

Recommendation ☐ Internet ☐ Advertising ☐ Other ……..……

Signed: ……..…… **Date:** ……..……

Please write down what you would like to discuss with the doctor today.

_____

_____

_____

Office check
No PO Box no
Check other Ph # – 1 mobile no not sufficient
All details entered in appropriate fields in MyIndici ie occupation/ethnicity etc
Enrolment form/ practice information sheet given/filled Enrolled on MyIndici?