The Broadway Surgery

PATIENT HEALTH QUESTIONNAIRE

Surname:

First Name(s):

Date of Birth: Male/Female

What is your Country of Birth?

Who is your Next of Kin?
Name/Consent No:

Do you smoke? Yes/No

Would You Like to Quit? [ ] [ ]

How much Alcohol do you drink a week?

Do you have any Allergies? Yes*/No
* Please give details [ ] [ ]

Are you allergic to any Antibiotics or Medications?
* Please give details Yes*/No

[ ] [ ]

Are you currently taking any Medications?
* please list medications

Have you had any of the following illnesses?
(If yes please give dates/year)

	Yes	No	Dates/Year(s)
Diabetes	[ ]	[ ]	
Asthma	[ ]	[ ]	
Epilepsy	[ ]	[ ]	
Cancer	[ ]	[ ]	
High Blood Pressure	[ ]	[ ]	

Stroke / Heart Problems [ ] [ ]

When did you have the following vaccinations/tests?

Polio	Date:
Tetanus	Date:
Pneumonia	Date:
Flu	Date:
Cervical Smear	Date:

MEDICAL HISTORY

Please give details including operations and any illnesses not listed above:

Please give details of any close relative(s) that suffered from Heart Disease/Stroke, Diabetes or Asthma at an early age (under 50 years).

Signature Date