THE COLERIDGE MEDICAL CENTRE

CANAAN WAY • OTTERY ST MARY • DEVON EX11 1EQ
Telephone: 01404 814447 • Fax: 01404 816716 • e-mail: coleridgemedicalcentre@nhs.net

PATIENT QUESTIONNAIRE

THIS INFORMATION WILL BE TREATED AS PRIVATE & CONFIDENTIAL			
Date completed		Date of Birth	
Surname		Marital Status	
Forenames		Occupation	
Previous Names			
Address			
	Please tick preferred contact no.	Postcode	
E-mail address		Next of kin (Name)	
Telephone		Relationship:	
Mobile		Contact Tel:	

MEDICAL HISTORY	
Are you in good health?	YES/NO
Have you had any previous, serious or recurrent illness, accidents or operations	YES/NO

Illness/Accidents/Operation	Year	Hospital (if appropriate)

Are you taking any medication?	YES/NO

Medication	Dose	For how long?

How often do you have a drink containing alcohol? (please circle your answer)	Never, Monthly or less, 2-4 times/month, 2-3 times/week, 4 or more times/week
How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2, or 4,5 or 6, 7 or 8, 10 or more (Please circle your answer)
How often do you have 6 or more standard drinks on one occasion?	Never, less than monthly, monthly weekly, daily or almost daily (please circle your answer)
Are you a	smoker Ex-smoker Never smoked
How much do you smoke per day and in what form?	

We strongly recommend all of our patients who smoke to consider stopping and have a 'Stop Smoking' clinic here in the surgery run by our practice nurses. If you are interested in attending please contact the surgery and make an appointment.

Are you allergic to anything?	
Are you visually impaired?	YES/NO

The following chart shows amounts of exercise over a 4 week period.
Please tick the box that describes the amount of exercise you take a month.

Activity of 20 minutes	Duration in previous 4 weeks	Tick
Vigorous	On 12 or more occasions	
Moderate/vigorous	On 12 or more occasions	
moderate	On 12 or more occasions	
Moderate/vigorous	On 5-11 occasions	
Moderate/vigorous	On 1-4 occasions	
None		

IN THE CASE OF WOMEN	
1. How many children have you had?	
2. Have you had a miscarriage or stillbirth?	
3. Are you on an oral contraceptive pill?	If yes name of pill:
4. How long have you been taking the oral contraceptive?	
5. Do you have an IUCD (coil) fitted?	If yes when was it fitted?

6. Do you have a contraceptive Impant (Nexplanon)?		If yes when was it fitted?	
7. Do you have a depo injection Contraception?		If yes when was it given?	
8. Have you had a breast check?	Doctor/Nurse	YES/NO	DATE
	Mammogram	YES/NO	DATE
9. Have you had a cervical smear test?		YES/NO	DATE

PREVIOUS IMMUNISATIONS

	DATE		DATE		DATE		DATE
Whooping cough		MMR		Measles		Diphtheria	
Polio		Tetanus		Rubella		Others	

FAMILY HISTORY

It would be helpful to know if anyone in your immediate family suffers or has died from any of the following illnesses, please tick below:

Relation	Glaucoma	Angina	Diabetes	High blood pressure	Asthma	Thyroid Disease
Father						
Mother						
Sisters/brothers						
Children						

If there have been deaths in the family from other causes please state below giving age and cause of death if known:-

Do you have any disability	YES/NO	
Do you have any family or social problems?		

Do you care for somebody who could not manage without your help?	YES/NO	IF YES	Name:
			Address:
Are they as child under 18?			
An adult with physical disability or illness?			
An adult with dementia or other mental health illness			
Are you cared for by somebody?	YES/NO		
Would you like a Carers Health Check?	YES/NO		

CURRENT

WEIGHT		HEIGHT		BLOOD GROUP	