THE SOUTHERN MEDICAL GROUP

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Welcome to the Southern Medical Group. Our practice would be grateful if you could take the time to complete this form. This will enable the medical staff to get to know a bit about you and any medical problems you may have. If you are at all concerned about any of the questions, then leave them blank. Your replies to these questions will be handled confidentially.

Please note that your health check is with the nurse and we would be grateful if you could bring your completed forms to this appointment.

Name …….. Date of Birth ……
(Please indicate: single/married/divorced/separated/widowed)

Address…….

Home Telephone No ……. Contact Telephone No ……

Present Occupation:

Social History:

Children:

<u>Illnesses, accidents of operations</u>
Please list all serious illnesses, accidents, hospital admissions or operations (With dates if possible) Please list any previous illnesses that you have.

<u>Medication</u>
Please list any medicine or tablets, which you are taking at present, and bring them with you to your health, check appointment.

<u>Allergies</u>
Are you allergic or sensitive to any medicines?

Questionnaire continued on page 2

Exercise
Please tick the category which best reflects your personal habits:

A	Exercise physically impossible ……		B	Avoids even trivial exercise	……
C	Enjoys light exercise	……	D	Enjoys moderate exercise	…….
E	Enjoys heavy exercise	……	F	Competitive athlete	……

Smoking
If you smoke, how much do you smoke each day?

A	Cigarettes	……..	B	Cigars	. ……..
C	Pipe	…….	D	Stopped smoking	…….
E	Never smoked	……..			

Alcohol
How many units do you drink per week? …….
(One "unit" = half a pint of beer/lager; one glass wine/sherry; or one measure of spirits)

Family History
Do any of your close relatives (parents, children brothers or sisters) suffer from either of the following illnesses?

Diabetes	Yes/No	**Family Member**
Heart Disease	Yes/No	
Stroke	Yes/No	
Thyroid Problems	Yes/No	
Asthma	Yes/No	
Cancer	Yes/No	
Osteoporosis	Yes/No	

WOMEN ONLY
Do you use contraceptives?
Please tick one. The Pill ……. Intra-uterine coil ……..
Diaphragm …… Sheath ……...
Other methods ……

Have you had a Cervical Smear? **Yes/No** **Date of last smear** ……..

Was your last smear done by your **GP** or at a **Hospital/Family Planning Clinic?**.....

Have your previous smears been normal? **Yes/No**

Have you ever attended Colposcopy Clinic? **Yes/No**

Are you pregnant? (this is to enable us to refer you on to our midwives and ensure you don't miss out on continued antenatal care)

Surgery Information Only Urinalysis ………