

Ethnic Group

White

- A British
B Irish
C Other white background

Mixed

- D White & Black Caribbean
E White & Black African
F White & Asian
G Other mixed background

Asian or Black Asian

- H Indian
I Pakistani
J Bangladeshi
K Other Asian background

Black or Black British

- L Caribbean
M African
N Other black background

Other Ethnic Categories

- O Chinese
P Any other Ethnic category – please state below:

Lifestyle

Tobacco consumption

- | | | | |
|---------------------------------------|--------------------------------------|---|---|
| Never Smoked <input type="checkbox"/> | Pipe Smoker <input type="checkbox"/> | Smoker <input type="checkbox"/> | Ex-Smoker <input type="checkbox"/> |
| | Oz per day <input type="text"/> | | Year Stopped <input type="text"/> |
| | | Less than 1 a day <input type="checkbox"/> | Less than 1 a day <input type="checkbox"/> |
| | | 1-9 a day <input type="checkbox"/> | 1-9 a day <input type="checkbox"/> |
| | | 10-19 a day <input type="checkbox"/> | 10-19 a day <input type="checkbox"/> |
| | | 20-39 a day <input type="checkbox"/> | 20-39 a day <input type="checkbox"/> |
| | | More than 40 a day <input type="checkbox"/> | More than 40 a day <input type="checkbox"/> |

Free NHS Stop Smoking Service on 0845 602 3608 or ask @ Dapdune Pharmacy

Body Mass

Height Weight Waist circumference

Alcohol consumption

- | | | | |
|------------------------------|---|---|--|
| Nil <input type="checkbox"/> | Occasional <input type="checkbox"/> | 1-7 Units a week <input type="checkbox"/> | 8-14 Units a week <input type="checkbox"/> |
| | 15-21 Units a week <input type="checkbox"/> | 22-35 Units a week <input type="checkbox"/> | 36-49 Units a week <input type="checkbox"/> |
| | | | More than 50 Units a week <input type="checkbox"/> |

One unit = ½ pint of beer/lager, 1 shot measure of spirits, 1 small glass of wine

Exercise

- Exercise impossible Light exercise Moderate exercise Vigorous exercise

In what form?

Disabilities

- | | | |
|---|------------------------------|-----------------------------|
| Are you housebound? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you suffer from severe hearing loss? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you Registered Blind? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you suffer from learning disabilities? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do you have a carer?

Yes

No

If Yes, please complete

Details of Carer

Name

Address

Telephone

Relationship to Patient (if any)

Are you a carer for someone?

Yes

No

If Yes, please complete

Details of Person you care for

Name

Address

Telephone

Relationship to Patient (if any)

Why do you care for them?

Family History

	State present health and serious illness suffered	If deceased Age at death	Cause of death
Father			
Mother			

Please tick if **your parents** have suffered from any of the following:

Father Heart Attack/ Angina High BP Stroke Asthma Diabetes Cancer

Mother Heart Attack/ Angina High BP Stroke Asthma Diabetes Cancer

Have any brothers/sisters died/suffered from serious illness? Yes No

Please state details

Your Health

Please tick if **you** have suffered, or are suffering, from any of the following:

Epilepsy Heart Attack/ Angina High BP Stroke Asthma Diabetes Cancer

Other illnesses, Operations & Accidents

Year	Details

Have you ever suffered any severe mental/nervous problems? Yes No

Please state details

Prescribed Drugs and Medicines

Please state below any medicines (including the contraceptive pill) **prescribed for you** by your GP

Name and strength of medicine	How often taken	Date started

Over the Counter Drugs and Medicines

Please state below any medicines you **buy for yourself**

Name and strength of medicine	How often taken	Date started

Have any had any allergies (to drugs or other materials)? Yes No

Please state details

How severe?

Adult Immunisations

Please complete if the patient is **over 16**

Injection	Y	N		Year	Month
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	When given	<input type="text"/>	<input type="text"/>

For Women Only

	Y	N		Year	Month
Have you had the Rubella jab?	<input type="checkbox"/>	<input type="checkbox"/>	When given	<input type="text"/>	<input type="text"/>
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
Have you had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
Have you had a cervical smear?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
Was it abnormal?	<input type="checkbox"/>	<input type="checkbox"/>			

If Yes, please give details

Please give the dates of any pregnancies, as shown below

Normal births	Caesarians	Miscarriages	Terminations