

Garswood Surgery

NHS Health Check Questionnaire

We would be grateful if you could kindly complete this survey.
Please be as honest as possible to help us to help you.

Name: _____ Male Female D of B: dd / mm / yyyy

Ethnicity (please tick)			
White		Asian or Asian British	Any other Black background
White British		Indian	Any other Ethnic Group
White Irish		Pakistani	Chinese
Any other white background		Bangladeshi	Irish Traveller
Mixed Heritage		Any other Asian Background	Traveller
White and Black Caribbean		Black or Black British	Gypsy/Romany
White and Asian		Black British	Other
White and Black African		Caribbean	
Any other mixed race		African	Ethnic group not given

Smoking Status - tick box(es) if YES and complete any additional information requested			
Non-smoker	<input type="checkbox"/>		
Ex Smoker	<input type="checkbox"/>	Date Ceased: dd / mm / yyyy	How many did you used to smoke per day?
Current Smoker	<input type="checkbox"/>	How many do you smoke per day?	Do you smoke a pipe or cigars? <input type="checkbox"/>

Alcohol Intake						
This test helps us to work out your drinking habits. The questions are about your use of alcohol in the last year. Please score according to your answer. eg, if your answer to Q1. is '2-4 times a month' then your score is 2						
		Scores				Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2 – 3 times a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have 6 or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes during the last year	
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes during the last year	

Physical Activity and Diet	
How many hours per week do you spend walking outdoors or in sporting activities or other exercise (including heavy housework)?	
How many portions of fruit and vegetables do you eat per day (typically)?	

Your Family History

Did / does any close relative (parents or siblings) have any of these diseases?

Diabetes

Father Mother Brother(s) Number: Sister(s) Number:

Stroke

Father Mother Brother(s) Number: Sister(s) Number:

Peripheral Vascular Disease (Hardening of the Arteries)

Father Mother Brother(s) Number: Sister(s) Number:

Angina

Father Mother Brother(s) Number: Sister(s) Number:

Heart Attack

Father Mother Brother(s) Number: Sister(s) Number:

Father Mother Brother(s) Number: Sister(s) Number:

Father Mother Brother(s) Number: Sister(s) Number:

Do you have any 1st degree relatives with Diabetes also diagnosed with angina, stroke and/or heart attack when they were aged less than 55 years (for males) or 65 years (for females) Yes No

Cancer

Type (if known)	Age when diagnosed	Which Family member

Early Detection and Support

Have you ever been told by a doctor that you have high blood pressure? Yes No

Have you ever been told by a doctor that you have high blood sugar (eg, in a health examination, during an illness or during pregnancy)? Yes No

Please list any over the counter medications that you purchase yourself on a regular basis (eg, pain killers, haemorrhoid treatments, indigestion remedies)

General Questions

Have you had any recent unexplained weight loss (not through dieting)? Tick if YES

Do you have a persistent cough? Tick if YES

Have you any recent bleeding from the back passage? Tick if YES

Have you had chest pain / tightness / indigestion in the past few months? Tick if YES

Do you get breathless walking about 100 yds / 90m on the flat? Tick if YES

Do you feel depressed / low mood most days? Tick if YES

Men only

When you pass urine does it take a while for it to start or is the flow interrupted? Tick if YES

Do you have to get up in the night at least twice to pass urine and / or find you can't last more than an hour in the day without needing to go to the toilet? Tick if YES

Do you have difficulty in maintaining or obtaining an erection? Tick if YES

Women only

Have you had any vaginal bleeding in between periods? Tick if YES

Have you any bleeding after sex? Tick if YES

If you have passed the menopause, have you had any vaginal bleeding since then? Tick if YES

Have you had any recurrent breast pain or noticed any change in the shape of your breasts? Tick if YES

Are you experiencing any problems with your home, such as keeping warm, dealing with repairs or hazards? Tick if YES

If you care for someone in your family, a friend or a neighbour who could not manage without your help then you are a Carer. The person you care for may require your help due to frailty, illness, learning or physical disability, sensory impairment, mental illness or addiction. Are you a carer? Do you have a carer?