Please complete one form for each member of your family and hand back to reception

1. Do you have any, or have had any of the following medical problems? Or is there a family history of the following:

Conditions	Self	Family	Conditions	Self	Family
Diabetes	☐ yes ☐ No	☐ yes ☐ No	Blood clot	☐ yes ☐ No	☐ yes ☐ No
High blood pressure	☐ yes ☐ No	☐ yes ☐ No	Stroke	☐ yes ☐ No	☐ yes ☐ No
Heart Disease or problem	☐ yes ☐ No	☐ yes ☐ No	High cholesterol	☐ yes ☐ No	☐ yes ☐ No
Heart attack <60yr >60yr	☐ yes ☐ No	☐ yes ☐ No	Migraine	☐ yes ☐ No	☐ yes ☐ No
Asthma	☐ yes ☐ No	☐ yes ☐ No	Epilepsy	☐ yes ☐ No	☐ yes ☐ No
Other lung or respiratory disease or problems	☐ yes ☐ No	☐ yes ☐ No	Breast cancer	☐ yes ☐ No	☐ yes ☐ No
Kidney disease or problems	☐ yes ☐ No	☐ yes ☐ No	Other cancer	☐ yes ☐ No	☐ yes ☐ No
Liver disease or hepatitis	☐ yes ☐ No	☐ yes ☐ No	Glaucoma	☐ yes ☐ No	☐ yes ☐ No
Bowel disease or problems	☐ yes ☐ No	☐ yes ☐ No	Rheumatic fever	☐ yes ☐ No	☐ yes ☐ No
Joint disease or problems, arthritis	☐ yes ☐ No	☐ yes ☐ No	Tuberculosis (TB)	☐ yes ☐ No	☐ yes ☐ No
Depression and/ or anxiety	☐ yes ☐ No	☐ yes ☐ No	Eczema	☐ yes ☐ No	☐ yes ☐ No
Other mental health illnesses	☐ yes ☐ No	☐ yes ☐ No	Hay fever	☐ yes ☐ No	☐ yes ☐ No

2. Do you have any **other health, disability problems or inherited conditions**? *-please list*

3. Please list any regular medications that you take

4. Have you had any operations? ☐Yes ☐ No , *if **yes** please list*

5. Are you **allergic** to any medication? ☐ yes ☐ No . *if **yes** please list*

6. Do you **smoke?** ☐ yes ☐ No . *if **yes,*** how many/ day ……………………
   If yes- would you like help to quit smoking ☐ yes ☐ No

7. Do you drink **alcohol ?** ☐ yes ☐ No If yes, on average, how much/ week…………and what type………………

8. Do you have any **substance abuse** problems? ☐ yes ☐ No

9. When was your last **Tetanus booster** ?

10. Are your childhood immunizations up to date ? ☐ yes ☐ No ☐ don't know

Women : *(those over 20 years and have ever been sexually active)*

11. When was your most recent cervical smear?

12. Have you ever had abnormal cervical smear?

13. Have you had a mammogram (those over 40 years)? ☐Yes ☐ No , *if **yes** when?*

Signed : *Date:*