Stratton Medical Centre, Hospital Road, Stratton, Bude, Cornwall
Tel: 01288 352133

Adult Patient Questionnaire

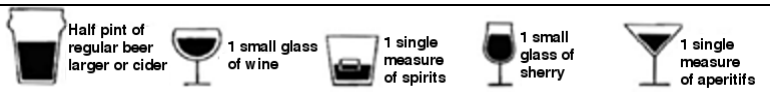
PERSONAL INFORMATION

Name:- Mr/Mrs/Miss/Ms	

Address:		Nationality:	
		Date of Birth:	
		Weight:	
Post Code:		Height:	
Tel No:		Waist Measurement:	

Current Smoker?	YES / NO	If yes to either how many cigarettes/cigars a day or Pipe/Roll your own oz/wk?	
Used to smoke?	YES / NO		
When did you give up?			

This is one unit of alcohol…



…and each of these is more than one unit

Scoring	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How would you describe your diet?	
How much exercise do you take?	None / 1x week / 2x week / more often
Form of exercise e.g. Swimming / Walking?	

Do you normally have a Flu vaccination?	YES / NO
Have you had a vaccination against Pneumonia?	YES / NO
If yes when did you have it?	

Have you ever had a Heart Attack or suffer from Chest Pains?			
Have you ever had Heart Surgery?	YES / NO	If yes when	

Are you a main carer for anybody?	YES / NO	If yes who	

For office use only	
C score	

Please continue over leaf

Have any members of your family suffered from any of the following:	
Condition / Illness	Member of family
Heart Attack < 60	
Heart Attack > 60	
Angina < 60	
Angina > 60	
Stroke	
Diabetes	
Asthma	

Have you got any medical conditions e.g., Diabetes, Asthma, Blood Pressure, Eye Problems?		
Please List:	1)	
	2)	
	3)	
	4)	
	5)	
	6)	

Have you had any operations?		
Please list.	1)	
	2)	
	3)	
	4)	
	5)	
	6)	

Do you have any allergies?	YES / NO
If yes please describe	

<u>If you take any medication please make an appointment to see a doctor.</u>

Please list below any immunisations you know or have records for.	
Immunisation:	Date:

When did you last have a Cervical Smear?	Date:	
Do you examine your Testicles regularly?	YES / NO	
Do you examine your Breasts regularly?	YES / NO	

Date:	Signature: