



Name:	
Address:	
Date of Birth:	
Occupation:	

Tel No:	Mobile No:
----------------	-------------------

Please circle which one applies to you

Do you Smoke:	YES/NO	How many years?
Would you like to stop?	YES/NO	How many per wk?
Have you ever smoked:	YES/NO	If YES, when did you stop

HEALTH HISTORY	Have you had?	Has any family member had?
Heart Attack	YES/NO	YES/NO
Angina	YES/NO	YES/NO
Cancer	YES/NO	YES/NO
Stroke	YES/NO	YES/NO
Diabetes	YES/NO	YES/NO
Asthma	YES/NO	YES/NO
High Blood Pressure	YES/NO	YES/NO
Epilepsy	YES/NO	YES/NO
Chronic Obstructive Pulm.Disease	YES/NO	YES/NO

DO YOU CONSIDER YOURSELF HOUSEBOUND?	YES/NO
---	--------

ARE YOU A CARER ?	YES/NO
If YES, please sign if you wish this to be recorded and complete the carers identification form at Reception.	Signature

ARE YOU ON REGULAR MEDICATION YES/NO	If YES please list below

Please circle which one applies to you

ETHNIC CATEGORY	Code		Code
British or Mixed British	.9i0	Pakistan or British Pakistan	.9i8
Irish	.9i1	Bangladeshi or British Bangkadeshi	.9i9
Other White background	.9i2	Other Asian background	.9iA
White and Black Caribbean	.9i3	Caribbean	.9iB
White and Black African	.9i4	African	.9iC
White and Asian	.9i5	Other Black background	.9iD
Other Mixed background	.9i6	Chinese	.9iE
Indian or British Indian	.9i7	Ethnic category not stated	.9iG

MAIN SPOKEN LANGUAGE		
Do you wish to state your main spoken lang.	YES/NO	.13ZG
If YES, please state		.13I

FORM COMPLETED BY:	Please complete page 2
DATE:	Administration to complete.
Please bring proof of identification with you	Initial id seen
Evidence of Identity	Record details
1- Driving Licence/ passport & number	
2- Address/ utility Bill etc	

HEALTH SUMMARY CONTINUED



For the following questions please circle the answer which best applies.

1 DRINK = 1/2 pint of beer or 1 glass of wine or 1 single spirit

1. MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than Monthly Monthly Weekly Daily or almost daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than Monthly Monthly Weekly Daily or almost daily

3. 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

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

Name:

Date of Birth: