OAK VALE MEDICAL CENTRE LIFESTYLE QUESTIONNAIRE 5

Please could you complete this questionnaire; it will enable our doctors and nurses to ensure that you receive appropriate medical care. If you need any advice or support on how to enjoy a healthy lifestyle, please make an appointment to see one of our practice nurses who will be happy to help.

1. PERSONAL DETAILS

Name: Date of birth: Occupation:

Address:` Email:

Tel. No. Work no. Mobile no.

2. ALLERGIES

Please let us know if you have any allergies e.g. to any medication/food/drink/material/substances

Allergic to …….

3. WEIGHT, HEIGHT & WAIST CIRCUMFERENCE

Weight ….. stones ….. pounds OR ……kilograms
Height ….. feet ….. inches OR ……metres

Waist measurement i.e. waist circumference ……..inches OR …….centimetres

4. SMOKING -Please let us know your smoking status

□ Never smoked
□ Smoke cigarettes or tobacco Number of cigarettes smoked **each day** …….
OR number of ounces of tobacco smoked **each day** …….
□ Smoke cigars Number smoked **each day** ……..
□ Smoke a pipe Number of ounces smoked **each day** ……..
□ Ex-smoker Number smoked **each day** …… Year gave up …….

If you are a smoker, there are many local services which can give you advice on how to stop smoking.
Would you like to have advice about stopping smoking? Yes □ No □
If yes, you will be contacted by a nurse to discuss the services available to you.

5. ALCOHOL - Please let us know how many units of alcohol you drink each week …….

A unit of alcohol is one of the following:
a standard glass of wine / a half pint of beer, lager or cider / a single measure of spirits (whisky, gin, bacardi, vodka etc.) / a small glass of sherry / a measure of vermouth or aperitif

6. EXERCISE –Please let us know how much exercise you take

By exercise, we mean a continuous activity which lasts at least 20 minutes e.g. cycling, swimming or brisk walking. ***How many times each week do you carry out such a session of exercise?***

□ Physically unable to exercise □ No exercise □ Once a week or less
□ 2-4 times a week □ 5 or more times a week

7. CARERS - **Do you care for a friend or relative** who is sick, disabled, elderly or has mental health problems or **are you cared for by a friend or relative** who helps you live your day-to-day life?

□ No □ Yes *If you answer yes, we shall send you a form to complete to record this in our records*

8. MILITARY VETERAN – Are you a military veteran? □ No □ Yes
MEDICATION - Is your medication in a blister pack? □ No □ Yes Code 66RD -8BIA

9. SUMMARY CARE RECORD

Are you happy for a Summary Care Record to be created for you on the central NHS computer system?

(please see attached leaflet for more details)

□ Yes □ No

10. FAMILY HISTORY

Have you or any member of your close family (i.e. mother/father/brother/sister/grandmother/ grandfather/aunt/uncle) had any of the following medical problems?

□ No □ Yes If yes, please give details below:-

Illness	**Family member**	**when did the illness start?**	
□ Angina	……..	when over 60 □	or under 60 □
□ Heart attack	……..	when over 60 □	or under 60 □
□ Heart disease	……..	when over 60 □	or under 60 □
□ Stroke	……..	when over 60 □	or under 60 □
□ Hypertension /high blood pressure	……..	when over 60 □	or under 60 □
□ Diabetes	……..		
□ Asthma	……..		

11. RELIGION

□ None □ Buddhism □ Christianity – Protestant □ Christianity – Catholic

□ Christianity other, please state …… □ Hinduism □ Islam □ Judaism □ Sikhism □ Jehovah's Witness □ Other – please state ……

12. COUNTRY OF BIRTH

Please state your country of birth …….

13. ASYLUM SEEKER - Are you an asylum seeker?

□ No □ Yes

14. ETHNIC GROUP – Please describe your ethnic group by circling the appropriate description

Asian Bangladeshi ∗ Asian Indian ∗ Asian Pakistani ∗ Asian other ∗ Black African ∗ Black Caribbean ∗ Black other ∗ Chinese ∗ Irish Traveller ∗ Mixed White & Asian ∗ Mixed White & Black African ∗ Mixed White & Black Caribbean ∗ Mixed other ∗ Somali ∗ White British ∗ White Irish ∗ White other ∗ Yemeni ∗ Other – please state ……..

15. MAIN SPOKEN LANGUAGE – Please tell us your main spoken language ……..

16. MAIN READING LANGUAGE

Arabic ∗ Bengali ∗ Braille ∗ Chinese ∗ Czech ∗ English ∗ French ∗ Hindi ∗ Polish ∗ Portuguese Punjabi ∗ Russian ∗ Somali ∗ Spanish ∗ Tamil ∗ Urdu ∗ Other – please state ……..

17. DO YOU NEED AN INTERPRETER/TRANSLATOR? □ No □ Yes

18. DO YOU USE ANY OF THE FOLLOWING?

□ British sign language □ Lip reading □ Loop system □ Minicom

Thank you for taking the time to complete this form.