The Wycliffe Medical Practice
NHS Health Check Questionnaire

In order to provide you with the best possible care, it is helpful if you can provide the following information.

Name	**Date of birth**	**Today's Date**

Please fill in this information at home or go to the Health Information Room as soon as you arrive at the surgery:

What is your height? _____

What is your weight? _____

What is your waist circumference? _____

Blood pressure _____

Pulse rate _____

If you monitor your blood pressure at home, please bring 10 readings done over the course of 5 days as these tend to be more accurate than surgery readings.

DATE	TIME	BLOOD PRESSURE	PULSE	COMMENTS

If you are able to calculate your average reading – please write it here:

To which of these ethnic origins do you belong?

☐ British	☐ Chinese	☐ African	☐ Other Black	☐ Other Mixed
☐ Mixed British	☐ Caribbean	☐ Indian	☐ White & Black African	☐ Other Asian
☐ Irish	☐ Pakistani	☐ Indian/British	☐ White & Black Caribbean	
☐ White & Asian	☐ Bangladeshi	☐ Other White	☐ I do not wish to disclose my ethnicity	

What is your first spoken language?

Do you smoke?	☐ YES	☐ NO
If YES – how many cigarettes do you smoke per day?	_____	
If you do not smoke now, have you ever smoked?	☐ YES	☐ NO
If so, how many did you smoke and when did you stop?	_____	

Do you ever have a drink that contains alcohol?	☐ YES	☐ NO
If YES – please complete page 3 of this questionnaire		

Do you take 'over the counter' Aspirin every day?	☐ YES	☐ NO

The following questions relate to your diet:		
Do you cook at home – how many times a week?	☐ YES ☐ NO	_____
Do you buy fresh fruit and vegetables?	☐ YES ☐ NO	_____
Do you eat red meat? How many times a week?	☐ YES ☐ NO	_____
Do you eat sugar free cereals for breakfast?	☐ YES ☐ NO	_____
Do you eat cakes and biscuits? How often?	☐ YES ☐ NO	_____
Do you use a chip pan or deep fat fryer?	☐ YES ☐ NO	_____
Do you eat ready meals? How many times a week?	☐ YES ☐ NO	_____
Do you have takeaways? How often and what type?	☐ YES ☐ NO	_____

Do your parents, grandparents, brothers or sisters have any history of the following?		
Heart disease	☐ YES ☐ NO	Family Member _____
Hypertension (High Blood Pressure)	☐ YES ☐ NO	Family Member _____
Stroke	☐ YES ☐ NO	Family Member _____
Diabetes	☐ YES ☐ NO	Family Member _____
Glaucoma	☐ YES ☐ NO	Family Member _____
Asthma	☐ YES ☐ NO	Family Member _____
Eczema	☐ YES ☐ NO	Family Member _____
Hay fever	☐ YES ☐ NO	Family Member _____
Cancer	☐ YES ☐ NO	Family Member _____
Thyroid disorder	☐ YES ☐ NO	Family Member _____
Stomach ulcers	☐ YES ☐ NO	Family Member _____
Depression	☐ YES ☐ NO	Family Member _____
Tuberculosis (TB)	☐ YES ☐ NO	Family Member _____

Do you or your family have any concerns about your memory?	☐ YES	☐ NO

Alcohol Questionnaire

If you drink alcohol please answer the following questions.

This quesionnaire refers to standard alcoholic drinks.

A standard drink containing one unit of alcohol is:

- ½ a pint of regular beer, lager or cider
- 1 small glass of wine
- 1 single measure of spirits
- 1 small glass of sherry
- 1 single measure of aperitifs

Questions	Answers				
How often do you have a drink that contains alcohol?	Never	Monthly or less	Once a month	2-3 times per week	4+ times per week
How many standard alcoholic units do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost

How often in the last year have you found that you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking	No		Yes, but not in the last year		Yes, during the last year
Has a relative/friend/doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year

Would you like information or advice about alcohol consumption?	☐ Yes	☐No