Date: ___/___/_____

HEALTH PROMOTION QUESTIONNAIRE

NAME: ……. DOB: ____/____/_____

Mobile telephone number: ……

Landline telephone number: …….

E-mail address : ……- is this shared with anyone else? Y / N

ETHNIC ORIGIN: ……

(i.e White British /White Irish/Afro Caribbean/Asian/Other)

Spoken Language: ……. Interpreter required? Y ? N

HEIGHT: ..... WEIGHT: ……

HAVE YOU HAD A PNEUMONIA VACCINATION? YES / NO What year? ……..

FOR WOMEN – (age of menopause if younger than 45 years) …….. years

HAVE YOU HAD YOUR CHOLESTEROL LEVEL CHECKED? YES / NO Abnormal / Normal

DO YOU HAVE ASTHMA? YES / NO

Are you currently using inhalers? YES / NO

When were your last night symptoms? (i.e. cough/wheeze/shortness of breath) …….. (date)

DO YOU HAVE EPILEPSY? YES / NO

Date of last seizure …….. (month and year)

DO YOU HAVE ANY DRUG ALLERGIES? YES / NO

If yes, which drugs? …….

DO YOU HAVE ANY PERSONAL HISTORY OF?

Diabetes YES / NO

High blood pressure YES / NO

Heart disease (i.e. Angina / Heart attack) YES / NO

TIA / Stroke YES / NO

FAMILY HISTORY

Have either of your parents or brother(s)/sister(s) had a history of?

	MALE	FEMALE	Approx age of diagnosis
Diabetes	YES / NO	YES / NO	
Hypertension	YES / NO	YES / NO	
Heart disease (i.e. Angina / Heart Attack/ Heart Failure)	YES / NO	YES / NO	
Stroke	YES / NO	YES / NO	

CARERS:

DO YOU CARE FOR / HELP LOOK AFTER ANOTHER PERSON? YES / NO

If yes, we would like to refer you to an organisation who can offer support to carers. Would you like somebody to contact you about this?

DOES SOMEONE HELP TO CARE FOR / LOOK AFTER YOU? YES / NO

Name, address and contact number:

NEXT OF KIN:

Name, relationship, address and contact number:

LIFESTYLE

ALCOHOL CONSUMPTION:

Questions	Scoring System 0	1	2	3	4	Your score
How often do you have a drink that contains alcohol?	Never	Monthly Or Less	2 -4 times Per month	2 – 3 times Per week	4+ times Per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 – 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily	

A score in excess of 5 could be harmful to your health. If you would like to discuss this matter further please make an appointment to see the practice nurse.

PHYSICAL ACTIVITY:

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
A	I am not in employment (e.g. retired, retired for health reasons, unemployed full-time carer etc.)	
B	I spend most o my time at work sitting (such as in an office)	
C	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
D	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. lumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
E	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the last week, how many hours did you spend on each of the following activities?

		None	Less than 1 hour	1 to 3 hours	3+ hours
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
B	Cycling, including cycling to work and during leisure time.				
C	Walking, including waking to work, shopping, for pleasure etc.				
D	Housework/Childcare				
E	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark 1 box only.

Slow pace ☐ Steady average pace ☐ Brisk pace ☐ Fast pace ☐

SMOKING:

Do you smoke? YES / NO

If yes, how many cigarettes do you smoke per day?

1 – 9 ☐ 10 – 19 ☐ 20 – 39 ☐ 40+ ☐

If you smoke tobacco in a pipe or in roll ups, how much tobacco do you smoke in a weeks?

…….. ozs.

If you do not currently smoke, have you ever smoked? YES / NO

If yes, when did you stop smoking? …….. (year).

……

Medical evidence shows that smoking damages health. The single most important thing that you can do to improve your health to stop smoking.

For information on smoking cessation please contact:

Cornwall Stop Smoking Service on: 01209 21566 or NHS Helpline freephone on: 0800 169 0169

If you are really serious about stopping smoking and need extra help please telephone the surgery and make an appointment for a Stop Smoking Consultation with a practice.