<u>Davidsons Mains Medical Centre</u> <u>Lifestyle Questionnaire - Adult</u>

<u>Introduction</u> - In order to help us focus our activities in the practice, we would be grateful if you would complete this short questionnaire. If you have already completed one on a previous visit, please return this questionnaire to the receptionist.

Title: Mr/Mrs/Miss/Ms (other)						Date			
Name					Date o	Date of Birth			
Address					Post C	Post Code			
Tel No:			Mob	oile:			Marital Status		
Email Addre	ss								
Have you been registered at the Practice before?						Yes	No		
Are you happy to contacted via text message?						Yes	No		
What if your	preferred pharr	macy to	send	your prescrip	tions to				
Next of Kin – Name						Tel No			
Next of Kin -	- Address								
	ic Grouping do ay: (Tick here)		s you	best? (Pleas	se Circle b	<u>elow)</u>			
White Indian	Black Caribb Pakistani					Black other Chinese Other Ethnic			
Do you smo	oke?	Yes	No	Ex Cigarett	e Smoker	Ex El	ectronic Cigarette Smoker		
If yes, do you	u:								
 1 - 9 cigarettes per day 10 - 19 cigarettes per day 20 - 39 cigarettes per day More than 40 cigarettes per day Smoke a pipe Smoke cigars Smoke an electronic Cigarette 									
<u>Alcohol</u>	emente am er	001101110	o.ga.						
	he statement, v ual to - 1 small ç			•	•		age alcohol intake. asure of spirit)		
I drink less the drink between I drink less the I d	alcohol (Teetonan 1 unit per den 1 and 2 uniten 3 and 6 uniten 7 and 9 uniten 9 unit	lay ts per da ts per da ts per da	ay ay	age					

Medication	
List of regular medication	
Are you a Carer? Are you being cared for by someone? Yes No Yes No	
Medical Information:	
Current Height	Current Weight
Past History	
Medical	
Surgical (operations etc)	
Hospital Admission	
Hereditary Conditions	
Present Health Condition	
Family History	
Diabetes	Hypertension
Heart Attack / Stroke	Asthma
Epilepsy	Last Flu/Pneumo Immunisation
Prescriptions We offer an Online Prescription Service for patient where view your medications. If you would like an account to be (this cannot be shared with anyone else). Only patients service.	created please supply an individual email address
Email address (not shared	
I wish to use Online Services. Please read each statement of	arefully and tick that you have understood.
I will be responsible for the security of the information that with anyone else, this is at my own risk. I will contact to account has been accessed by someone without my again.	the practice as soon as possible if I suspect that my record that is not
about me or is inaccurate, I will contact the practice as so	oon as possible.
For practice use only: ID verified Date	Date Account Created