Your personal health risk questionnaire

The information you provide in this questionnaire will help ensure that your clinician has an accurate and complete picture of your health status and history, to help you get the most informed advice and guidance about your health. Information provided is covered by medical confidentiality and will not be disclosed to anyone other than your clinician.

BLOSSOMS
HEALTHCARE

GP SERVICES • EXECUTIVE MEDICALS • OCCUPATIONAL HEALTH

Personal details								
Name								
Title	Mr		Mrs		Ms		Other	
Date of birth								
Telephone no.								

Your job role
Please describe briefly an average day at work. e.g. number of hours spent commuting each day, whether your work is in any way physically demanding.

Your family history
Are there any medical problems that run through your family from generation to generation, e.g. diabetes, asthma, heart disease, Bowel Cancer, etc?

Please provide details of the state of health or cause or death of your immediate family				
		Living		Deceased
	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Your lifestyle					
Are you a smoker?		Are you an ex-smoker?		Are you a non-smoker?	
If you smoke, how many do you smoke per day?		For ex-smokers, when did you stop & how much did you used to smoke?			

Do you drink alcohol?	Yes		No	
If yes, how many units do you consume each week?				
NB. 1 unit = ½ pint of beer/lager, a standard spirit measure or a small glass of wine.				

Do you take regular exercise? Please indicate how much and what type of exercise you would undertake during an average week.
Are you conscious of your nutritional intake? Please indicate when and what you would eat during an average day. Do you eat an excessive amount of any type of food, e.g. crisps, cakes, chocolate, red meat, etc.

Your health status

	Yes	No	Details
Are you in good health?			
Have you recently been receiving medical treatment?			
Do you suffer from any form of disability?			
Are you taking any medication? If yes, please list			

	Yes	No	If yes, do you wear them for (please tick)	
			Distance/driving	
Do you wear glasses?			Reading/near	
Do you wear contact lenses?			VDU work	

	Yes	No
Do you suffer from a defect of colour vision?		
Do you suffer from monocular vision (sight in only one eye)?		

Your medical history		
Do you suffer from/have you ever suffered from one or more of the following? (please tick)	Yes	No
Heart problems, e.g. angina, heart attacks, etc		
High blood pressure		
Chest diseases (asthma, bronchitis, tuberculosis, etc)		
Diabetes		
Stomach or bowel problems		
Liver/gall-bladder disorders		
Kidney/bladder disorders		
Disease of reproductive system		
Epilepsy		
Other neurological disorders (e.g. stroke, migraines)		
Psychological disorders (anxiety, depression, stress, other)		
Neck/back problems		
Muscle, tendon or joint problems of the arms or legs		
Skin problems (e.g. eczema, psoriasis, dermatitis)		
Sleep disorders e.g. persistent insomnia/sleep apnoea		
Any serious accident/injuries		
Deafness/ear disorders		
Vertigo		
Hernia/ruptures		
Blood disorders		
Cancer		
Any medical condition, operation or treatment not already mentioned		
Are you happy in your current job role?		
Do you feel in control of your working life?		
Do you feel the demands you face at work are manageable?		
If yes, please give brief details (including dates whenever possible) for any of the above, indicating appropriate dates/duration of illness, treatment and referral to specialist		