the practice
broughton gate health centre

INTRODUCTION

This document is intended to be completed by patients to provide basic health information.

HEALTH QUESTIONNAIRE

Name: ____________________________________ Date of Birth: _________________________

SMOKING

Do you smoke? Yes/No If Yes, how many per day?_____________

If you smoke, how old were you when you started?__________________________________

EX-SMOKERS

If you used to smoke, how old were you when you stopped?_________________________

If you used to smoke, how many times did you smoke per day?______________________

PASSIVE SMOKING

Are you exposed to smoke at work? Yes/No At home? Yes/No

Would you like to Quit Smoking? Yes/No

EXERCISE

How many minutes do you exercise for at a time?__________

How many times per week?______________________________

DIET

Do you consider your diet healthy? Yes/No

Do you add salt to your food after cooking? Yes/No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No

Has your Cholesterol been checked in the last 2 years? Yes/No