**MALE PATIENT QUESTIONNAIRE**

**DATE:** ……………………………….. **MALE**

**SURNAME:** ……………………………………………… **FIRST NAMES:** ……………………………………………………………………………….

**ANY PREVIOUS SURNAME** …………………………………………………………………………………………………………………………………

**ADDRESS:** ……………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………...

**TELEPHONE: HOME** ……………………………………………………………. **WORK** ………………………………………………………………..

**MOBILE**  ……………………………………………………… **EMAIL:** …………………………………………………………………………………………

**CAN WE LEAVE A MESSAGE ON: HOME/WORK/MOBILE**

**CAN WE CONTACT YOU BY EMAIL?** **YES/NO TEXT MESSAGE? YES/NO**

**OCCUPATION**:………………………………………………………. **MARITAL STATUS:**……………………………………………………………

**NEXT OF KIN: - NAME:** ……………………………………………… **PHONE NUMBER:**………………………………………………………….

**RELATIONSHIP TO YOU: (e.g daughter)** ……………………………………………………………………………………………………………

**ARE YOU A CARER:** YES/NO **DO YOU HAVE A CARER:** YES/NO

**DETAILS OF YOUR CARER/WHO YOU CARE FOR:** ………………………………………………………………………………………………

**ADDRESS/CONTACT NO’S:** …………………………………………………………………………………………………………………………………

**MAIN LANGUAGE SPOKEN:** ………………………………………………………. **INTERPRETER NEEDED:** YES/NO

**SUMMARY CARE RECORDS:** **DO YOU CONSENT** YES/NO**. OVER 75 - NAMED DR GIVEN**: …………………………………

**2. PERSONAL MEDICAL HISTORY**

**DO YOU SUFFER FROM OR ARE YOU RECEIVING TREATMENT FOR ANY OF THE FOLLOWING CONDITIONS?**

HEART DISEASE HEART FAILURE SCHIZOPHRENIA

STROKE HIGH BLOOD PRESSURE BIPOLAR AFFECTIVE DISORDER

DIABETES ASTHMA EMPHYSEMA/CHRONIC BRONCHITIS

EPILEPSY CANCER THYROID DISEASE

SPLENECTOMY KIDNEY DISEASE DEMENTIA

**3. SMOKING STATUS**

**DO YOU SMOKE?** YES/NEVER/EX SMOKER**: IF YES HOW MANY PER DAY?** ………………………………………...................

**IF GIVEN UP. DATE YOU GAVE UP SMOKING**: ………………………………………

**4. ALLERGIES:**

**DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS:** YES/NO

**IF YES, PLEASE LIST:** ……………………………………………………………………………………………………………………………………………

**5. ALCOHOL INTAKE- FOR THE FOLLOWING QUESTIONS PLEASE CIRCLE THE ONE THAT BEST APPLIES**

**(1 DRINK/UNIT = ½ PINT OF BEER OR 1 GLASS OF WINE OR 1 SINGLE SPIRIT)**

**DO YOU DRINK ALCOHOL?** YES/NO **HOW MANY UNITS PER WEEK:** …………………………………………………………………

**MEN: HOW OFTEN DO YOU HAVE EIGHT OR MORE DRINKS ON ONE OCCASION?**

**WOMEN: HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION?**

*NEVER LESS THAN MONTHLY MONTHLY WEEKLY DAILY ALMOST DAILY*

**HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER WHAT HAPPENED THE NIGHT BEFORE BECAUSE YOU HAD BEEN DRINKING?**

*NEVER LESS THAN MONTHLY MONTHLY WEEKLY DAILY ALMOST DAILY*

**HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS NORMALLY EXPECTED OF YOU BECAUSE OF DRINKING?**

*NEVER LESS THAN MONTHLY MONTHLY WEEKLY DAILY ALMOST DAILY*

**IN THE LAST YEAR HAS A RELATIVE OR FRIEND, DOCTOR OR HEALTH WORKER BEEN CONCERNED ABOUT YOUR DRINKING OR SUGGESTED THAT YOU CUT DOWN.**

*NO YES, ON ONE OCCASION YES, ON MORE THAN ONE OCCASION*

**6.DIET/EXERCISE**

**DO YOU TAKE REGULAR EXERCISE OR SPORT** YES/NO

**PLEASE GRADE YOURSELF ON A SCALE OF 1 – 10 (1 BEING NO EXERCISE) GRADE**: …………………………………………..

**DO YOU FOLLOW A SPECIFIC KIND OF DIET? EG VEGETARIAN, VEGAN. DETAILS;** ………………………………………………

**7. FAMILY HISTORY**

**HEART DISEASE BEFORE AGE 60 YES/NO FAMILY MEMBER:** ……………………………………………

**HEART DISEASE AFTER AGE 60 YES/NO FAMILY MEMBER:** ……………………………………………

**STROKE** **YES/NO FAMILY MEMBER:** ……………………………………………

**HIGH BLOOD PRESSURE YES/NO FAMILY MEMBER:** ……………………………………………

**DIABETES YES/NO FAMILY MEMBER:** ……………………………………………

**ASTHMA YES/NO FAMILY MEMBER:** ……………………………………………

**COLON CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**PROSTATE CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**BREAST CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**GLAUCOMA YES/NO FAMILY MEMBER:** ……………………………………………

**8. MEDICAL SUMMARY**

**PLEASE LIST ANY SERIOUS ILLNESSES, HOSPITAL ADMISSIONS OR OPERATIONS THAT YOU HAVE HAD.**

|  |  |
| --- | --- |
| **DATE** | **PROBLEM** |
|  |  |
|  |  |
|  |  |

**9. ETHNICITY**

**WHAT IS YOUR ETHNIC GROUP?**

**A: WHITE**

**BRITISH**

**IRISH**

**ANY OTHER WHITE BACKGROUND PLEASE STATE ……………………………………………………………………………**

**B: MIXED**

 **WHITE AND BLACK CARRIBEAN**

 **WHITE AND BLACK AFRICAN**

 **WHITE AND ASIAN**

 **ANY OTHER MIXED BACKGROUND. PLEASE STATE ……………………………………………………………………………**

**C. ASIAN OR ASIAN BRITISH**

**INDIAN**

**PAKISTANI**

**BANGLADESHI**

**ANY OTHER MIXED BACKGROUND, PLEASE STATE …………………………………………………………………………………………**

**D. BLACK OR BLACK BRITISH**

**CARRIBEAN**

**AFRICIAN**

**ANY OTHER BLACK BACKGROUND, PLEASE STATE …………………………………………………………………………………………**

**E. CHINESE OR OTHER ETHNIC GROUP**

**CHINESE**

**ANY OTHER PLEASE STATE ……………………………………………………………………………………………………………………………..**

**NOT STATED**