PROF KEFFORD HEALTH QUESTIONNAIRE

PATIENT _____ **DATE** _____

GP's Name _____

FAMILY HISTORY: If any blood relative has suffered any of the following please circle and indicate which relative:

Epilepsy	**Diabetes**	**Anaemia**	**Heart Disease**	**Alcoholism**	**Arthritis**
Migraine	**Thyroid**	**Easy Bleeding**	**Stroke**	**High Cholesterol**	**Glaucoma**
Mental Illness	**Hay Fever**	**Osteoporosis**	**Hypertension**	**Asthma**	
Cancer of:					

PERSONAL HISTORY: List Previous Hospital Admissions (not including pregnancies):

Year	Illness or Operation	Hospital Year	Illness or Operation Hospital
_____		_____	_____
_____		_____	_____
_____		_____	_____

List All Current Medications and Dosage:
(include those you buy without a prescription)

_____
_____
_____
_____
_____
_____

Year of Last Vaccination:

Tetanus / TD	_____
Influenza (FLU)	_____
Pneumonia	_____
Hepatitis A	_____
Hepatitis B	_____
TB Skin Test	_____

List Allergies to medications

_____
_____
_____
_____
_____
_____

Have you ever had: (Please Tick Yes or No)

	Y	N		Y	N		Y	N
High Blood Pressure			Frequent Infections or Boils			Haemorrhoids or Rectal Disease		
Low Blood Pressure			Nervous Breakdown			Kidney Disease		
Heart Disease			Anaemia			Gonorrhoea or Syphilis		
Diabetes			Epilepsy			Bladder Disease		
Tuberculosis			Meningitis			Scarlet Fever, Scarletina		
Influenza			Thyroid Disease			Measles		
Pleuritis (Pleurisy)			Hay Fever			German Measles		
Pneumonitis (Pneumonia)			Asthma			Rheumatic Fever		
Arthritis or Rheumatism			Hives or Eczema			Chicken Pox		
Bursitis, Tendonitis			Migraine Headaches			Diphtheria		
Neuritis or Neuralgia			AIDS/HIV			Mumps		
Any Bone or Joint Disease			Gallbladder Disease			Small Pox		
Sciatica, Back Pain or Lumbago			Colitis or other Bowel Disease			Whooping Cough		
Food, Chemical or Drug Poisoning			Jaundice or Liver Disease			Cancer (type):		

Have you ever:

	Y	N
Had Blood or Plasma Transfusions?		
Been advised to have any surgical or medical treatment which has not been done?		
Drink Alcohol. How Much?		
Smoke. How many per day?		
Use recreational Drugs. What kind?		

INJURIES: Have you had any of the following:

	Y	N
Broken or Cracked Bones		
Dislocations		
Concussion or Head Injury		

What is your weight? Now _____ One year ago _____ Maximum Weight Ever _____ When_____ **Height**: _____
Date of your last Pap Smear_____/_____/_____ Date of your last Mammogram_____/_____/_____
Please give age at which you had your first period, number of pregnancies, age of your children, and date of last menstrual period:

_____