ABBEY SURGERY
HEALTH QUESTIONNAIRE

Name:_____ Patient Number:_____
(If known)

_____

Date of Birth:_____

In order for us to better understand your current health status please complete the boxes below that apply to you.
Please provide as much detail as possible.

Exercise:

How often do you exercise?

0 times/week ☐ 1 times/week ☐ 2 times/week ☐ 3+times/week ☐

Alcohol:

How much do you drink:

Number of units/week: ☐

Smoking:

Do you currently or have you ever smoked?

Never smoked ☐ Passive Smoker ☐ Ex-Smoker ☐ Current Smoker ☐

If Current Smoker how many?

Cigarette smoker ☐ per/day Rolls Own ☐ oz/week
Pipe smoker ☐ oz/week Cigar smoker ☐ per/day

If ex-Smoker how many?

Ex-cigarette smoker ☐ per/day Ex-Rolls Own ☐ oz/week
Ex-Pipe smoker ☐ oz/week Ex-Cigar smoker ☐ per/day

Allergies:

Do you have any allergies?
Please state what they are and what reaction you have?

Do you have any drug allergies? (such as Penicillin)

Thank you for your time and trouble which will help us to further improve your health care.