Dr Christopher J Corbin MRCS LRCP

The Sanctuary, 5 Priory Gardens, Isleham, Ely, Cambridgeshire.

HEALTH ASSESSMENT

Please complete this questionnaire and bring it with you.

I want to be able to understand as much about you and your health as possible in the time available. This questionnaire will help to jog your memory about family history and aspects of your own health. This will help me and save precious time when you are with me.

PERSONAL DETAILS

Title Mr .... Mrs .... Miss .... Ms .... Other (please indicate) ....

Full Name ....

Date of Birth .... Age .... Nationality ....

Home Address ....

....

....

Postcode .... Dentist None........ Private......... NHS........ (please tick)

Tel (Home) .... (Business) ....

E-mail .... (Mobile) ....

NHS No. (10 digits) .... Private medical insurance? Yes .... No ....

Please complete the following if your employer is paying for this assessment:

Company Name .... Company Address...

....

INFORMING YOUR NHS GP

GP Name .... GP Telephone ....

GP Address ....

It is good practice for your GP to be kept informed of any developments related to your health. Please sign here if you are happy for Dr Corbin to send your GP a brief summary of your consultation with him, including any abnormalities or significant results which may require further investigation or treatment.

Signature .... Date ....

PLEASE TELL ME YOUR MAIN REASONS FOR ATTENDING

Review of health .... Medical problem .... Company requirement .... Other reason ....

Do you have any specific areas of health interest or concern? Yes .... No ....

Are you planning to retire soon or have you recently retired? Yes .... No ....

Please outline what you would like to get out of this health assessment:

YOUR GENERAL HEALTH

Do you have any problems in the following areas which you would like to discuss? Please tick and add notes:

			Doctor's notes:
Eyes			
Ears, nose, throat			
Mouth, teeth			
Skin			
Glands			
Breathing			
Cough, phlegm			
Asthma			
Bronchitis			
Headaches			
Sleep			
Stress			
Tiredness			
Muscles			
Joints			
Osteoporosis			
Arm pain			
Palpitations			
High blood pressure			
Poor circulation			
Weight			
Appetite, digestion			
Difficulty swallowing			
Abdominal pain			
Change in bowel action			
Blood or mucous in motions			
Blood in urine			
Pain passing urine			
Incontinence, losing urine			
Sexual matters or problems			
Contraception			
Sexually transmitted diseases			
Other			

MARITAL STATUS

If this is your first visit or there has been a change since your last visit please give details below:

Are you:

Single .... Married .... Civil Partnership .... Divorced .... Separated .... Widowed .... Cohabiting ....

If married / civil partnership, for how long? .... years

Spouse / partner's age and occupation ....

Health of spouse / partner Good .... Fair .... Poor ....

Number of children Sons .... Daughters ....

FAMILY HISTORY

If this is your first visit or there has been a change since your last visit please give details below:

	Age(s) if alive	Age at death	State of health / cause of death	*Doctor's notes*
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

Do you have any family history of:

	Yes	Details		Yes	Details
Diabetes			Aortic aneurysm		
Heart attack			High blood pressure		
Angina or bypass			Glaucoma		
Bowel cancer			Prostate cancer		
Breast cancer			Osteoporosis		
Ovarian cancer			Stroke		

YOUR JOB HISTORY

Are you currently working? Full time .... Part time .... Retired ....

If yes, what is your job title? ....

Please give brief details of what your job entails ....

Have you served in the armed forces? If yes, please give details ....

Have you worked in or visited the tropics? ....

How many years in your current employment? .... How many hours on average a week, total .... , at home ....

How many nights a week away from home? .... How long does your journey to work take? ....

How many business miles a year? .... How many days off work due to sickness in the last two years? ....

YOUR LIFESTYLE

Doctor's notes:

Smoking:

Do you smoke? Never / Given up / Yes Cigarettes / Cigars / Pipe (delete as applicable)

If given up, when? .... How many / how much per day? ....

If you are a non-smoker, are you regularly exposed to a smoky atmosphere? Yes / No

Alcohol:

How often do you drink alcohol? .... days per week on average

Do you drink at lunchtime? Usually / Often / Occasionally / Never

How many units typically per week? .... units

Have you recently felt you should cut down on your drinking? Yes / No

Have people annoyed you by criticising your drinking? Yes / No

Have you ever felt bad or guilty about your drinking? Yes / No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes / No

Has drinking ever affected your driving or job? Yes / No

Drugs:

Do you use any recreational drugs? Please specify ... ... Yes / No

Exercise:

Aerobic exercise is continuous bodily activity sufficient to increase your breathing rate ***moderately.***

How much aerobic exercise do you take?

20 minutes or more how many times a week? (please circle) 4+ 3 2 1

What sort of exercise? ....

Are you active as part of your daily routine? Yes / No

Other than formal exercise, what other activities do you do regularly?

....

Diet:

How many portions of fruit and vegetables do you eat each day on average? ....

Do you generally eat more chicken and fish than red meat? Yes / No

How many times a week, on average, do you eat red meat? ....

How many times a week, on average, do you eat cheese, butter, cream? ....

How many times a week, on average, do you eat processed meat? ....

How many times a week, on average, do you eat snack foods, crisps and nuts? ....

How many times a week, on average, do you eat chocolate, biscuits or cake? ....

How many cups of water, fruit or herbal tea, juice, squash (non-fizzy) per day? ....

How many cups of caffeinated drinks per day? Tea .... Coffee ....

Has your weight been steady recently? Yes / No Up / Down How much? ....

YOUR MEDICAL HISTORY

Have you had any of the following? ***Please give details and dates:***

	Tick	Details	Date(s)	*Doctor's notes:*
Heart disease, chest pain, palpitations, high blood pressure or other blood vessel disease				
Asthma, bronchitis, pneumonia or other lung disease				
Persistent indigestion, ulcer, colitis, hepatitis or other disease of the liver, pancreas or bowel				
Recurrent urinary infection, kidney disease or stones				
Arthritis, rheumatic disease, gout, back pain, spinal , bone, joint or muscle disease				
Fits, blackouts, epilepsy, paralysis, stroke or other nervous system disease				
Depression, anxiety, mental breakdown or psychiatric problem				
Diabetes, thyroid or other glandular disorder				
Anaemia, blood disorder				
Ears, nose and throat problems				
Glaucoma, eye problems				
Sexually transmitted infection, HIV / AIDS				
Tropical disease, malaria etc				
Blood transfusion				
Skin problems, eg eczema, psoriasis				
Sterilisation or vasectomy				
Disease of ovary, cervix or uterus				
Any other condition, surgical operation, tumour or serious injury				

YOUR RECENT HEALTH

In the past year, have you suffered from or been unable to work because of the following:
(If yes, approximately how many days were you unable to work?)

	Yes	No	No of days not worked	*Doctor's notes:*
Back pain				
Other muscle or joint pain				
Colds, flu, virus infection				
Headaches				
Period pain, PMT				
Gastric upsets				
Stress				
Other illness				
Injury				
Accidents				
Assault				

MEDICATION

Please list any medicines or supplements you are taking, either prescribed or bought over the counter :

ALLERGIES

Please list any allergies, *including allergies to medicines :*

HOSPITAL ADMISSIONS

Please give details of any hospital admissions in the last three years:

TESTS and INVESTIGATIONS

Have you had any of the following tests?

	Details	Where?	When?
X-ray, mammography, CT or MRI scans, ultrasound			
ECG, echocardiogram, angiogram			
Endoscopy, colonoscopy			
Other specialist investigation			

YOUR WELLBEING

Please read this carefully. I would like to know how your health has been in general **over the past few weeks.** Please answer ALL the questions by ticking the answer which you think most applies to you. **Have you recently:**

been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Worse than usual	Much worse than usual ....
lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual ....
felt you were playing a useful part in things?	More so than usual	Same as usual	Less so than usual	Much less than usual ....
felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less than usual ....
felt constantly under strain?	Not at all	No more than usual............	Rather more than usual	Much more than usual ....
felt you couldn't overcome your difficulties?	Not at all	No more than usual............	Rather more than usual	Much more than usual ....
Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual ....
been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less than usual ....
been feeling unhappy and depressed?	Not at all	No more than usual............	Rather more than usual	Much more than usual ....
been losing confidence in yourself?	Not at all	No more than usual............	Rather more than usual	Much more than usual ....
been thinking of yourself as a worthless person?	Not at all	No more than usual............	Rather more than usual	Much more than usual ....
been feeling reasonably happy, all things considered?	More so than usual	Same as usual	Less so than usual	Much less than usual ....

ABOUT YOUR WORK

If you are in employment, for each question indicate the one answer that best describes your job or the way you deal with problems occurring at work. Please answer ALL the questions.

Do you have to work very fast?	Often	Sometimes	Seldom	Never ....
Do you have to work very intensively?	Often	Sometimes	Seldom	Never ....
Do you have enough time to do everything?	Often	Sometimes	Seldom	Never ....
Do you have the possibility of learning new things through work?	Often	Sometimes	Seldom	Never ....
Does your work demand a high level of skill or expertise?	Often	Sometimes	Seldom	Never ....
Does your job require you to take the initiative?	Often	Sometimes	Seldom	Never ....
Do you have to do the same thing over and over again?	Often	Sometimes	Seldom	Never ....
Do you generally decide how you do your work?	Often	Sometimes	Seldom	Never ....
Do you have a good deal of say in decisions about your work?	Often	Sometimes	Seldom	Never ....

HEALTH QUESTIONS FOR MEN

Doctor's notes:

Do you regularly examine your testes? Yes No

Have you ever noticed any lumps or swellings in your testes? Yes No

Do you regularly get up at night to pass urine? Yes No

If yes, how many times? ....

Have you noticed any change in the flow rate or stream of your urine? Yes No

Do you have difficulty in starting or stopping passing urine? Yes No

Do you have any problems with sexual function? Yes No

HEALTH QUESTIONS FOR WOMEN

When was your last cervical smear? Date / /

What was the result? ....

Have you ever had an abnormal smear? Yes No
If yes, please give age and details

Do you have any concerns about your breasts? Yes No
If yes, please give details

Have you ever had a mammogram? Yes No
If yes, when and where was the last one performed and what was the result?

Have you ever had a breast problem or needed breast surgery? Yes No
If yes, please give details

Are you breast aware and do you know how to examine your breasts? Yes No

Has any member of your family had cancer of the breast, ovary or any other gynaecological cancer? Yes No
If yes, please give their age at diagnosis and details

HEALTH QUESTIONS FOR WOMEN *continued*

Doctor's notes:

Is breast tenderness a problem? Yes No
If yes, please give details

When was your last period? Date / /

Have your recent periods been regular? Yes No

Do you have any problems with your periods? Yes No

Are pre-menstrual symptoms a problem? Yes No

Are you sexually active? Yes No

Do you have any sexual problems? Yes No

Are you using contraception? Yes No

Is vaginal discharge a problem? Yes No

Do you have any bleeding between periods or after intercourse? Yes No

Have you undergone any gynaecological treatment or operations? Yes No
If yes, please give age and details

Have you had your menopause? Yes No If yes, at what age?

Do you have menopausal symptoms, eg hot flushes, night sweats? Yes No

Are you taking hormone replacement therapy (HRT)? Yes No
If yes, please give name of product

Would you like to discuss HRT? Yes No

Have you ever been treated for infertility? Yes No

Have you ever been pregnant? Yes No
If yes, please give details

Were the pregnancies and deliveries normal? Yes No

Would you like to discuss pre-conceptual care? Yes No

CLINICAL FINDINGS

BP:

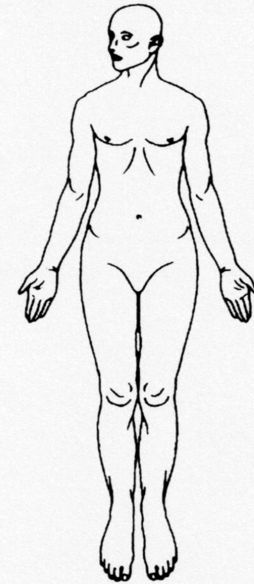
Pulse:

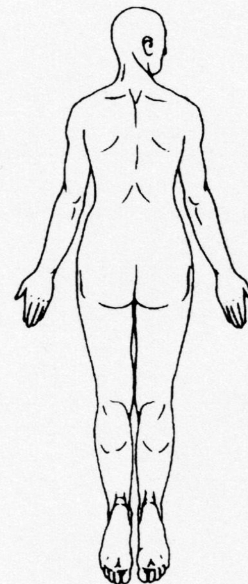
Appearance:

Build:

Mood and rapport:

	Normal	Abnormal	Comment
Eyes			
Ears and nose			
Mouth and throat			
Teeth and gums			
Skin			
Lymph glands			
Central NS			
Peripheral NS			
Heart size			
Heart rhythm			
Heart sounds			
Carotids			
Upper resp tract			
Lungs			
Peripheral arteries			
Veins			
Abdominal palpation			
Abdominal organs			
Hernial orifices			
Rectum			
Prostate			
Male genitalia			
Axial skeleton			
Upper limbs			
Lower limbs			





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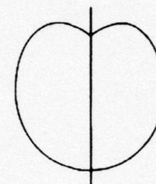


PSA Test: Done ☐ Not done ☐

PSA counselling Yes ☐ No ☐

Reasons:

Clinical findings

Audiology:

Additional tests:

Significant results / trends:

Action Plan:

GP letter:

Framingham CHD risk score

Sex	
Age	
Total cholesterol	
HDL cholesterol	
Blood pressure	
Diabetes	
Cigarette smoking	
Point total	
CHD risk	
Comparative risk	

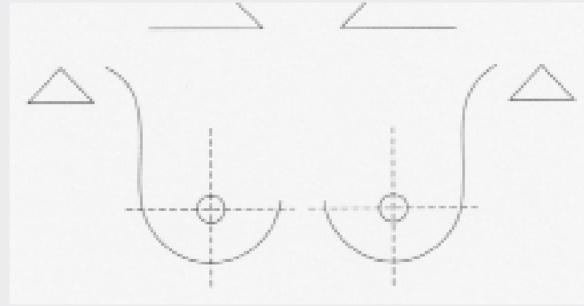
Report:		
Patient	GP	Co MO
Co lay	Other	

Signature ______________________________

Date ______________________________

Clinical findings - women

Past breast history:



Present symptoms:

Hormones Yes No

Clinical summary:	**Right**	**Left**		**Right**	**Left**
Normal			Nipple normal		
Benign abnormality			Nipple inverted		
Suspic. abnormality			Nipple discharge		

Mammography Yes No

Reason:

Recommendations: Routine review Clinical recheck Referral

GYNAECOLOGICAL assessment

Clinical:

Abdomen:	Abnormal	**Vulva**	Normal	Abnormal		
Vagina:	Abnormal	Intacta	Prolapse	Discharge		
Cervix:	Normal	Atrophic	Cont. Bld	Absent	Polyp	Nab. foll
	Ectopia	Suspic.	Cervix fully vis		360 deg sweep	
Uterus:	Normal	Abnormal	Absent	Mobile	Fixed	
Position:	A/V	R/V	Axial			
Adnexae:	Normal	Abnormal				
Cx. smear:	Yes	No	Vault			
HVS:	Yes	No				
HPV test:	Yes	No				
HPV counselling:						