# Well Person Questionnaire

**Surname: …….Forenames: ……**

**Date of Birth: ……..**

**Address: …….**

**……**

**Tel : …….Mobile: ……..Fax: ……**

**Works Tel: …….**

**Next of Kin: ……..Relationship……**

**Tel: ……....**

## Medical History

Please tick the box if you suffer from any of the following:

**Diabetes □ Heart Disease □ Asthma □ Stroke □ Depression □**

**Mental Health Problems□ Epilepsy □ Hypertension □**

**Height……..**

**Weight…….**

**Smoking Status Smokes□ Ex Smoker□ Non Smoker□**

**If you are a smoker and wish to give up please tick here □**

**List of current Medications:**

| | |
|---|---|
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |
| …… | …… |

**Please bring all medications with you when you attend your health check.**