NEW PATIENT QUESTIONNAIRE

This questionnaire has been designed to help your new Doctor get to know you and your medical history. The information given will be handled confidentially. Please complete as many of the questions as you can.

NAME ..... *(PLEASE PRINT)*

MARITAL STATUS Single / Married / Divorced / Separated / Co-habit / Widow Date of Birth .....

NAME AND ADDRESS OF LAST DOCTOR

.....

.....

.....

Do you have family already registered at this Surgery? ☐ *NO* ☐ *YES .....*

Are other family members Registering with you? ☐ *NO* ☐ *YES .....*

OCCUPATION .....

.....

DATE OF RETIREMENT .....

.....

ALLERGIES .....

.....

HEIGHT .....

WEIGHT .....

Is your weight stable? ☐ *NO* ☐ *YES* ☐ *RECENTLY LOST WEIGHT* ☐ *RECENTLY GAINED WEIGHT*

Immunisations *(and date if possible)*

☐ *Diptheria .....* ☐ *Rubella .....* ☐ *Pneumonia.....* ☐ *Influenza ....*

☐ *Smallpox .....* ☐ *Measles .....* ☐ *Tetanus .....* ☐ *Whooping Cough .....*

☐ *Polio .....* ☐ *T.B. .....*

Do you drink alcohol?

☐ *NO*

One unit = half pint of beer ☐ *YES - Beer .....* *units per week (approx)*

One unit = one glass of wine ☐ *YES - Wine .....* *units per week (approx)*

One unit = one measure of spirits ☐ *YES - Spirits .....* *units per week (approx)*

Do you smoke tobacco?

☐ *NO - Never smoked*

☐ *NO - Ex-smoker*

☐ *YES - Cigarettes .....* *daily (approx)*

☐ *YES - Cigars .....* *daily (approx)*

☐ *YES - Pipe .....* *daily (approx)*

Family History

Does anyone in your family have a history of any of the following? Please tick more than one if applicable.

	Mother	Father	Brother	Sister
ASTHMA	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
OTHER	☐	☐	☐	☐

Illnesses, Accidents, Operations

Please list past history of major illnesses and/or hospital attendances, together with dates i(f possible).

....

....

....

....

....

....

Current Medication

If you feel that it would be helpful, bring your current medicines to your appointment - the Nurse will be happy to answer your questions.

....

....

....

....

....

....

Do you take regular exercise?

☐ *NO* ☐ *YES*

How often? ....

Any other relevant information ....

....

....

WOMEN ONLY

Have you ever had a Cervical smear? ☐ *YES* ☐ *NO* *Date of last smear* ....

Have you ever had an abnormal smear? ☐ *YES* ☐ *NO*

Have you ever had a Mammogram? ☐ *YES* ☐ *NO* *Date* ....

Do you use any form of contraception? ☐ *YES* ☐ *NO* *Is yes, please detail* ....

Have you had any miscarriages? ☐ *YES* ☐ *NO* *Is yes, please detail*..........................

Do you have any children? ☐ *YES* ☐ *NO*

☐ *Date of Birth*	☐ *Normal Delivery*	☐ *Forceps*	☐ *Caesarean Section*	☐ *Male*	☐ *Female*
☐ *Date of Birth*	☐ *Normal Delivery*	☐ *Forceps*	☐ *Caesarean Section*	☐ *Male*	☐ *Female*
☐ *Date of Birth*	☐ *Normal Delivery*	☐ *Forceps*	☐ *Caesarean Section*	☐ *Male*	☐ *Female*
☐ *Date of Birth*	☐ *Normal Delivery*	☐ *Forceps*	☐ *Caesarean Section*	☐ *Male*	☐ *Female*
☐ *Date of Birth*	☐ *Normal Delivery*	☐ *Forceps*	☐ *Caesarean Section*	☐ *Male*	☐ *Female*

Signed .... *Date* ....