

**NEW PATIENT QUESTIONNAIRE**

*If you prefer not to answer any question – please leave blank*

*If you can’t remember the exact date – give an estimate*

NAME…………………………..…………….

DATE OF BIRTH……..……………………

OCCUPATION……………………………..

**Medical History**

|  |  |  |
| --- | --- | --- |
| Have you had any operations?  (include tonsils, appendix, male or female sterilisation) | Year |  |
| Have you ever been into hospital for any other illnesses? | Year |  |
| Have you ever seen a specialist about any other problem or had any other special tests?  *Please give details e.g. ECG, colonoscopy* | Year |  |
| Do you have any long term illnesses or disability?  *Please give details eg raised blood pressure, diabetes, asthma* | Year |  |
| Are you fully immunised?  When was your last tetanus vaccination? |  |  |

**Medications**

|  |  |
| --- | --- |
| Please list any current medication |  |
| Are you allergic to any medications?  *If so, please give details* |  |

**Family history**

*Please circle below and provide details*

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma | High blood pressure | Stroke | Heart disease |
| Glaucoma | Bowel Cancer | Breast Cancer | Any other inherited disease |

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**Lifestyle**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke currently? | Yes/No | Number of cigarettes per day |  |
| Have you ever smoked? | Yes/No | What year did you stop? |  |
| Do you drink alcohol? | Yes/No | How much? | …..per day ……per week |
| What sort of exercise do you do? |  | How often? |  |

**Women**

|  |  |
| --- | --- |
| Number of children | Year/s born |
| Other pregnancies | Year/s |
| Form of contraception (if relevant) |  |
| Last cervical smear | Month Year |
| Last mammogram | Month Year |