



New patient questionnaire

Please complete this form as fully as possible. The information will be of importance to provide you with good medical care.

Name		Sex M/F
Address		DOB
		Tel no.
	Postcode	Marital status
Previous surname (if any)		Nationality
Occupation		Ethnic group
Next of kin (name)		
Relationship (Tel no)		
Are you a smoker? Yes <input type="radio"/> No <input type="radio"/>		(Please tick as appropriate)
Have you ever smoked? Yes <input type="radio"/> No <input type="radio"/>		(Please tick as appropriate)
If you have stopped smoking please give the date		

Please list any serious illness, accidents, operations, disabilities
Women - please include any problems in pregnancy or at delivery

Please give present state of health and any serious illnesses in the family
(if deceased, please state age at death and cause of death)

IN PARTICULAR CAN YOU PLEASE GIVE DETAILS OF ANY FAMILY HISTORY OF HEART DISEASE

Father
Mother
Brothers
Sisters
Children



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What is your height?	What is your weight?
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Have you any allergies? If so, what?

Do you drink alcohol? Yes No *(Please tick as appropriate)*

If yes, approximately how much?

When was your last tetanus injection?

When was your last polio vaccination?

Are you currently taking any medicines or having any treatment? Yes No *(Please tick as appropriate)*

If yes, please give details

Do any medicines upset you? Yes No *(Please tick as appropriate)*

If yes, please give details

Are you in good health at the present time? Yes No *(Please tick as appropriate)*

Is there anything you would like us to know?

Are you a carer? Yes No *(Please tick as appropriate)*

Do you have a carer? Yes No *(Please tick as appropriate)*

If you have answered 'Yes' to either of the above questions please give the name and address of the person for whom you are a carer or who cares for you.

Women

Have you had a cervical smear test? Yes No *(Please tick)* When?

Have you had breast screening? Yes No *(Please tick)* When?