Stoddard Road
MEDICAL CENTRE

New Patient Medical Questionnaire

Please complete one form for each memberof your family and hand back to reception

Name: **Occupation:**

1. Do you have any, or have had any of the following medical problems?, or is there a family history of the following :

	Self	Family		Self	Family
Diabetes	Yes ◯	Yes ◯	Blood clot	Yes ◯	Yes ◯
High blood pressure	Yes ◯	Yes ◯	Stroke	Yes ◯	Yes ◯
Heart disease or problems	Yes ◯	Yes ◯	High cholesterol	Yes ◯	Yes ◯
Heart Attack <60yr >60yr	Yes ◯	Yes ◯	Migraine	Yes ◯	Yes ◯
Asthma	Yes ◯	Yes ◯	Epilepsy	Yes ◯	Yes ◯
Other lung or respiratory disease or problems	Yes ◯	Yes ◯	Breast cancer	Yes ◯	Yes ◯
Kidney disease or problems	Yes ◯	Yes ◯	Other cancer	Yes ◯	Yes ◯
Liver disease or Hepatitis	Yes ◯	Yes ◯	Glaucoma	Yes ◯	Yes ◯
Bowel disease or problems	Yes ◯	Yes ◯	Rheumatic Fever	Yes ◯	Yes ◯
Joint disease or problems, arthritis	Yes ◯	Yes ◯	Tuberculosis (TB)	Yes ◯	Yes ◯
Depression and/or anxiety	Yes ◯	Yes ◯	Eczema	Yes ◯	Yes ◯
Other mental health illnesses	Yes ◯	Yes ◯	Hay Fever	Yes ◯	Yes ◯

2. Do you have any **other health, disability problems or inherited conditions**? – *please list*

3. Please list any **regular medications** that you take

4. Have you had any **operations**?	Yes ◯	No ◯	If **yes**, please list
5. Are you **allergic** to any medications?	Yes ◯	No ◯	If **yes**, please list
6. a) Do you **smoke**?	No ◯	Yes ◯	If yes, how many / day
b) Have you ever smoked?	No ◯	Yes ◯	If yes, how much and for how long when did you give up
7. Do you drink **alcohol**?	No ◯	Yes ◯	If yes, on average , how much / week and what type
8. Do you have any substance abuse problems?	Yes ◯	No ◯	

9. Women: *(those over 20 years & sexually active)*

When was your most recent cervical smear?

Have you ever had an abnormal smear? Yes ◯ No ◯ Don't know ◯

Have you had a mammogram (those over 40 years)? No ◯ Yes ◯ If Yes, when?

10. When was your last **Tetanus booster**?

11. Are your **childhood immunisations** up to date? Yes ◯ No ◯ Don't know ◯

(Please bring in your child's vaccination record for us to update our records)

Signed: Date:

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this.

Please be careful to disclose all important medical/surgical/psychiatric information