

NEW PATIENT QUESTIONNAIRE

Please print out and bring this to the initial consultation.

Please complete as many questions as you can. This information is strictly confidential.

General information:

NameDate of Birth
Address
.....
..... Post Code.....
Phone numbers: Home Work
Mobile

GP's nameSurgery
Post CodePhone number

Do you have healthcare insurance? Yes / No
If so which company?
.....

Your birth

Please give details of your birth (premature, normal, forceps, difficult, breech, caesarian)
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.....
.....

Childhood illnesses.

Please state roughly when you had these and if they were severe.

- Chicken pox Yes/No
- German measles Yes/No
- Mumps Yes/No
- Scarlet Fever Yes/No
- Whooping Cough Yes/No

Personal Medical History

Please list any serious or chronic illness, operations, accidents or injuries or disabilities. Please give approximate dates where possible. (Please write on the back of this page if necessary).

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.....
.....

<u>Have you ever suffered from:-</u>	<u>Date</u>
High Blood pressure	Yes/No
Heart or Blood Vessel Disease	Yes/No
Heart attack	Yes/No
Stroke/Seizures	Yes/No
Diabetes	Yes/No
Asthma/ Eczema	Yes/No
Cancer	Yes/No

Are you at present under the care of your GP or a consultant?

Drugs and Medicines

Please list any drugs, medicines, tablets or contraceptive pills that you may be taking.

Name of Medicine	Dosage if Known
1.
2.
3.
4.
5.

Accidents

Have you had any accidents, falls or injuries? Eg. Car accidents, sporting injuries etc.

	Date
1.
2.
3.

Operations

Give brief details of any operations.

	Date
1.
2.
3.
4.

Family History

Mother: Date of Birth.

Overall Health

Any specific health problems.....

Father: Date of Birth.....

Overall Health.....

Any specific health problems.....

Grandparents, siblings, aunts and uncles

Please give as much information as possible regarding the overall health, including major illnesses and cause of death of these relatives. (Use the reverse for additional info).

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Social History

Occupation Marital Status

Do you smoke? Yes/No How many per day?

Do you drink? Yes/No How many units per week?

Do you take regular exercise or play sport? Yes/No

Which sports?.....

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.....

Vaccinations/Inoculations

Please state which ones you have had with dates. Did you have bad reactions to any of them?

	Date
1.
2.
3.
4.
5.
6.
7.