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| **New Patient Questionnaire** | | | | | | | | | | | | | | | | | | | | | | | |
| **PERSONAL INFORMATION** | | | | |  | | | | | | | | | | | | | | | | | | |
| SURNAME: | |  | | | | FORENAME: | | | | | |  | | | | DATE OF BIRTH: | | | | |  | | |
| MARITAL STATUS: | | | |  | | | | | | | | | | SEX: | | |  | | | | | | |
| ADDRESS: |  | | | | | | | | | | | | | | | | |  | | | |  | |
| TELEPHONE NUMBER:  MOBILE NUMBER: | | |  | | | | | | | | | EMAIL ADDRESS: | | | | | | |  | | | | |
| SURNAME AT BIRTH: | | | |  | | |  | | | | | | | TOWN OF BIRTH: | | |  | | | | |  | |
| NEXT OF KIN (*with contact details*) | | | | | | | |  | | | | | | | | | | | | | | | |
| Named Carer for Patient (*if applicable*) | | | | | | | |  | | | | | | | | | | | | | | | |
| Do you or have you ever served in the UK armed forces? | | | | | | | | YES NO | | | | | | | | | | | | | | | |
| **HEALTH INFORMATION** | | | | |  | | | | | | | | | | | | | | | | | | |
| DO YOU SMOKE? | | | | | YES NO | | | | | | HAVE YOU EVER SMOKED? | | | | | | | | | YES NO | | | |
|  | | | | | | | | | | | IF YES HOW MANY PER DAY? | | | | | | | | |  | | | |
|  | | | | | | | | | | | IF YES DATE STOPPED | | | | | | | | |  | | | |
| HEIGHT | | | | |  | | | | | | WEIGHT | | | | | | | | |  | | | |
| DO YOU DRINK ALCOHOL? | | | | | YES NO | | | | | | | | IF YES HOW MANY UNITS PER WEEK? | | | | | | | | | |  |
| DIET (*mixed/vegetarian/other*) | | | | | | | | | | | |  | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | |  | | | | | | | | | | | | | | | | | | |
| ILLNESSES *(e.g. DIABETES/ASTHMA/HEART ATTACK/CANCER/TB/HIGH BLOOD PRESSURE etc.)* | | | | | | | | | | OPERATIONS *(e.g. TONSILECTOMY/ HYSTERECTOMY/VASECTOMY etc.)* | | | | | | | | | | | | | |
| YEAR DIAGNOSED | | | | DETAILS | | | | | | YEAR | | | | | DETAILS | | | | | | | | |
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| **FAMILY MEDICAL HISTORY** | | | |  | | | | | | | | | | | | | | | | | | | |
| ILLNESSES *(e.g. DIABETES/ASTHMA/HEART ATTACK/CANCER/TB/HIGH BLOOD PRESSURE etc.)* | | | | | | | | | | | | | | | | | | | | | | | |
| YEAR DIAGNOSED | | | | DETAILS | | | | | YEAR DIAGNOSED | | | | | | DETAILS | | | | | | | | |
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| **MEDICATION** | *PLEASE GIVE DETAILS OF ANY MEDICATION AND DOSAGE* | | | | | | | | | | | | | |
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| **FEMALE HISTORY** | | |  | | | | | | | | | | | |
| HOW MANY PREGNANCIES HAVE YOU HAD? | | | | | |  | | | DATES | |  | | | |
| HAVE ANY OF THEM ENDED IN: | | | | | | IF YES WHICH ONE? | | |  | | | | | |
| MISCARRAIGE | | YES NO | | | |  | | |  | | | | | |
| STILLBIRTH | | YES NO | | | |  | | |  | | | | | |
| DIFFICULT DELIVERY | | YES NO | | | |  | | |  | | | | | |
| ARE YOU USING ANY FORM OF ORAL CONTRACEPTION? | | | | | | YES NO | | | IF YES, FOR HOW LONG? | | | | |  |
| HAVE YOU HAD A CERVICAL SMEAR TEST? | | | | | YES NO | | | IF YES, WHEN AND WHERE? | | | | |  | |
|  | | | | | IF NO, WOULD YOU LIKE ONE? | | | | | YES NO | | | | |
| HAVE YOU EVER HAD BREAST SCREENING? | | | | | YES NO | | | IF YES WHEN AND WHERE? | | | |  | | |
| **FURTHER DETAILS** | | | | PLEASE GIVE DETAILS | | | | | | | | | | |
| ANY DISABILITIES  (*e.g. blind/deaf/amputations etc*) | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |
| ANY ALLERGIES/SENSITIVITIES  *(e.g. Penicillin/Aspirin/Skin reaction etc.)* | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |
| **IMMUNISATION/VACCINATION RECORD** | | | | | | | PLEASE GIVE DETAILS | | | | | | | |
| **DETAILS** | | **YEAR** | | | | | | | | | | | | |
| POLIO TRIPLE | |  | | | | | | | | | | | | |
| TETANUS | |  | | | | | | | | | | | | |
| MMR | |  | | | | | | | | | | | | |
| BCG | |  | | | | | | | | | | | | |
| OTHER *(please state)* | |  | | | | | | | | | | | | |