

**PATIENT QUESTIONNAIRE**

**CARERS:**

**Are you are Carer? Yes / No**

If you are Carer, please complete the name(s) of the person(s) you care for and your relationship:

Cared for: \_\_\_\_\_

Relationship to Carer: \_\_\_\_\_

**FOR WOMEN ONLY:**

Have you ever had a cervical smear? Yes / No

What was the date of the last one? \_\_\_\_\_

Are you using either contraceptives or a coil? \_\_\_\_\_

If so, which one? \_\_\_\_\_

How long have you been using the above \_\_\_\_\_

**PREGNANCIES:**

Please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had a hysterectomy? Yes / No

If so, when and where? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thank you very much for completing this questionnaire.**

**Please make sure you have a Practice Leaflet.**

This questionnaire is designed to help your new doctor get to know you and to assist with any medical problems you may have. If you are concerned or have difficulty with any of the questions, please leave them blank and they can be discussed with doctor when you attend surgery.

Please bring the completed questionnaire with you for your first appointment and also a sample of urine, in the container provided.

Any information given will be handled in the strictest confidence.

Date Questionnaire completed \_\_\_\_\_

**PERSONAL HISTORY:**

SURNAME: \_\_\_\_\_

FORENAMES: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ POST CODE \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

MOBILE NUMBER: \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

MARITAL STATUS: Single / Married / Separated / Divorced / Widowed / Other

OCCUPATION: \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

CONTACT TELEPHONE NUMBER \_\_\_\_\_

**FAMILY HISTORY** (Please give particulars as to your family)

	LIVING STATE OF HEALTH	DECEASED AGE AT DEATH	DECEASED CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			

**PERSONAL HEALTH HISTORY**

**IMMUNISATION HISTORY** – please state if you have been immunised against any of the following illnesses, **giving dates where possible**

Whooping Cough	_____	Typhoid	_____
Diphtheria	_____	Cholera	_____
Polio	_____	Influenza	_____
Tetanus	_____	Tuberculosis	_____
Measles, Mumps, Rubella	_____	Hib	_____
Any Others	_____	Meningitis	_____

**PAST MEDICAL HISTORY**

Please list, giving dates of any:

- Operations:
- Hospital Admissions:
- Serious Accidents:
- Disabilities:

**PRESENT MEDICAL HISTORY**

Are you under the care of a Hospital Consultant at present? \_\_\_\_\_

If so, who? \_\_\_\_\_

where? \_\_\_\_\_

Are you awaiting any investigations to be carried out? \_\_\_\_\_

Are you awaiting any results of any investigations? \_\_\_\_\_

Do you have any private medical insurance? \_\_\_\_\_

please give details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATION**

Please list all medications you are presently taking, giving strengths and dosage.

NAME OF MEDICATION	STRENGTH	DOSAGE (how many times per day)

**ALLERGIES**

Are you allergic to any medications, foods, animals etc.?

Please state: \_\_\_\_\_

\_\_\_\_\_

**SMOKING AND ALCOHOL**

Do you smoke? Yes / No

What do you smoke? Cigarettes / Pipe / Cigars

How much do you smoke? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Have you ever smoked? \_\_\_\_\_

When and how many \_\_\_\_\_ per day for \_\_\_\_\_ years  
until \_\_\_\_\_ years ago.

How much alcohol do you drink per week? \_\_\_\_\_

Whereabouts do you drink? \_\_\_\_\_

**WEIGHT AND HEIGHT**

Do you know what your weight is? \_\_\_\_\_

Have you lost or gained weight recently? Lost / Gained

How tall are you? \_\_\_\_\_