

**NEW PATIENT QUESTIONNAIRE**

Name ..... Date of Birth .....

Address ..... Marital Status Married   
Single   
Divorced   
Widowed   
Separated

Telephone Number ..... E-Mail Address .....

Occupation .....

Are you a Carer?  Main carer for someone else?  Who for? .....

Which ethnic group do you belong to? – You are not obliged to complete this section

Please ✓ as appropriate

- White  Chinese  Indian  Bangladeshi  
 Pakistani  Black-African  Black Caribbean  Other – please state .....
- I do not wish to give this information

Other members of household:-

Name	Age	Relationship
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**Medical History**

Previous Serious Illnesses	Operations and dates
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Have you had a tetanus booster in the past 10 years Y/N (please circle)

**How many times per week do you exercise for 20 minutes or more?** .....

**Current Height** ..... **Current Weight** .....

ADDITIONAL INFORMATION REQUIRED – PLEASE SEE OVERLEAF

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**Present regular medication (please list name, strength and how often taken)**

Name	Strength	How often taken
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

**Drug Allergies**

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**Family History**      Is there anyone in your family who has had

Heart Disease	<input type="checkbox"/>	Please give details	-----
Stroke	<input type="checkbox"/>	Please give details	-----
Cancer	<input type="checkbox"/>	Please give details	-----
Diabetes	<input type="checkbox"/>	Please give details	-----
High Blood Pressure	<input type="checkbox"/>	Please give details	-----
Asthma	<input type="checkbox"/>	Please give details	-----
Tuberculosis	<input type="checkbox"/>	Please give details	-----

**Smoking Habits**

Smoker       Number of cigarettes/cigars per day      -----

Non-Smoker     

Ex-Smoker       Date Stopped      -----      Number of cigarettes/cigars per day      -----

**Alcohol Intake**

Please estimate your alcohol intake per week (1 unit = half pint beer or 1 glass wine or 1 measure spirit)

Number of units per week      -----

**Women Only**

Pregnancies (Year)	1	2	3	4
Any Known Problems? – Please state	-----			
Last Cervical Smear	When	Where	By Whom	
Are you taking the contraceptive pill	Y/N (please circle)			
Are you using any other contraception	Y/N (please circle)			

**Date Form Completed**      -----