MEDICAL QUESTIONNAIRE

SURNAME: FORENAME(S): DATE OF BIRTH:

STATUS: Single/married/separated/divorced/cohabiting/widowed

ADDRESS: (incl. postcode)

LANDLINE:
MOBILE:

ETHNIC STATUS: e.g. White British/White Scottish/Gypsy/Traveller/Indian, etc

OCCUPATION: WHO LIVES WITH YOU?

- PLEASE LIST ANY OPERATIONS YOU HAVE HAD:
- PLEASE LIST ANY CURRENT MEDICAL PROBLEMS:
- PLEASE LIST ANY ALLERGIES:
- PLEASE LIST AND TABLETS, MEDICINES OR OTHER TREATMENTS YOU ARE TAKING, INCLUDING THOSE FROM THE CHEMIST:
- ARE THERE ANY SERIOUS ILLNESSES THAT AFFECT MEMBERS OF YOUR FAMILY?
- WOMEN ONLY – WHEN DID YOU LAST HAVE A BREAST SCAN……..…….. AND/OR CERVICAL SMEAR……?
- WHICH OF THESE IMMUNISATIONS HAVE YOU HAD? PLEASE CIRCLE & DATE, IF POSSIBLE:-

  Diptheria Measles Rubella (German Measles) Tetanus

  MMR (Measles/Mumps/Rubella) Polio Pertussis (Whooping Cough)

  Please list any other immunisations:

- DO YOU SMOKE? IF YES, HOW MANY CIGARETTES DO YOU SMOKE PER DAY?
  - The NHS offers a range of services and supports to help you stop smoking, please tick here to confirm that you are aware these services are available to you.
  - Please tick here if you would like to have a further discussion with the GP about stopping smoking.
- DO YOU DRINK ALCOHOL? IF YES, HOW MUCH EACH WEEK?
- WHAT SORT OF EXERCISE DO YOU TAKE?
- PLEASE DESCRIBE ANY SPECIAL DIET YOU FOLLOW?