QUESTIONNAIRE FOR NEWLY REGISTERED PATIENTS

Please answer the questions as best you can.
This information will be kept on file in your notes and will be treated with the same confidentiality as any other information given to your doctor or medical staff looking after you.

Name D.O.B. Height

Address Tel. No. Weight

B.M.I

Occupation Marital Status BP

Urinalysis

Previous GP's name + address

Past Medical History

Major Illnesses Date of Diagnosis

Operations Date of Treatment

Last Tetanus Vaccination

Present/Ongoing Medical Problems

Allergies

Smoking Yes ☐ Number of cigarettes or oz. Tobacco per day

Never ☐ Stopped ☐ Date stopped

Alcohol No ☐ Yes ☐ Number of units per week

1 unit = 1 glass of wine, 1 measure of spirits or ½ pint of beer

Present Medications
(Tablets, sprays, eye drops etc., which you use regularly)

Drug	Dose

Carers: Do you currently care for someone ? Yes ☐ No ☐

Does someone care for you ? Yes ☐ No ☐

Family History

	Alive	Age	Any Medical Problems	Dead	Age at Death	Cause of Death
Father						
Mother						
Brothers						
Sisters						

Females only

Have you had a hysterectomy

Yes ☐ No ☐

When did you have your last cervical smear ☐

Date	Normal	Abnormal

Have you ever had a breast examination Yes ☐ No ☐

Date	Normal	Abnormal

Have you ever had a mammogram Yes ☐ No ☐

Date	Normal	Abnormal

How many times have you been pregnant ? ☐

How many children have you had ? ☐

Do you take the oral contraceptive pill ? Yes ☐ No ☐

Do you have a coil fitted ? Yes ☐ No ☐

Have you had your Rubella (German Measles) Vaccine ? Yes/Date ☐ No ☐