BLACKFRIARS MEDICAL PRACTICE

NEW PATIENT MEDICAL QUESTIONNAIRE

PERSONAL DETAILS

Title & Full Name: _____
Date of Birth: _____
Full Address: _____
_____
_____ Post Code: _____
Home Telephone Number: _____
Alternative Telephone Number: _____

CURRENT MEDICAL DETAILS

Do you smoke? YES / NO. If yes, how many cigarettes per day _____
Are you an ex-smoker? YES / NO

Do you drink alcohol? YES / NO. If yes, how many units per week _____

What is your weight? _____ What is your height? _____

Have you ever had a smear **(female patients only)** YES / NO
If yes, when was this taken? _____
What was the result? NEGATIVE / ABNORMAL

Do you have any allergies? YES / NO. If yes, please provide details _____

PAST MEDICAL HISTORY

Please detail all important, previous, illnesses, hospital admissions and operations with dates:
_____
_____

Are you on any regular medication? YES / NO. If yes, please provide details:
_____
_____

Have any of your relatives had any of the following conditions? If so, please detail who:
Asthma _____ Heart Disease _____
Epilepsy _____ Diabetes _____
Stroke _____ High Blood Pressure _____

Have you ever had any immunisations / vaccinations? YES / NO. If yes, please provide details with dates:
_____
_____
_____
_____

OTHER INFORMATION

Please provide details of your next of kin (name, address, relationship, telephone number)
_____
_____