STONEFIELDS
MEDICAL CENTRE

New Patient Medical Questionnaire

Please complete one form for <u>each member</u> of your family and hand back to reception

Name:____ **DOB:** ______/______/________

1. **Do you have any, or have had any of the following medical problems?, or is there a family history of the following:**

	Self	**Family**		**Self**	**Family**
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart Attack <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

2. Do you have any **other health, disability problems or inherited conditions**? – *please list*

3. Please list any **regular medications** that you take

4. Have you had any **operations?** ☐ Yes ☐ No *If **yes**, please list*

5. Are you **allergic** to any medications? ☐ Yes ☐ No *If **yes**, please list*

6. Do you **smoke?** ☐ No ☐ Yes If yes, how many / day ________________________
If Yes - would you like help to **quit smoking** ☐ Yes ☐ No

Have you ever smoked ☐ No ☐ Yes If yes, how much and for how long __________________
when did you give up____________________

7. Do you drink **alcohol?**☐ No ☐ Yes If yes, on average , how much / week __________________
and what type__________________________

PLEASE TURN OVER AND COMPLETE BACK PAGE

8. Do you have any **substance abuse** problems? ☐ Yes ☐ No

9. **<u>Women:</u>** (*those over 20 years & sexually active)*

When was your most recent cervical smear? ____________________

Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know

Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when?_________

10. When was your last **Tetanus booster**? ____________________

11. Are your **childhood immunisations** up to date? ☐ Yes ☐ No ☐ Don't know

Signed:__________________________________ Date:_____________________________